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# **A Qualitative Study of Counsellors' Experience of Compassion Fatigue**

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“Dissertation submitted to the University of Chester for the Degree of Master of Arts (Counselling Studies) in part fulfilment of the Modular Programme in Counselling Studies,” June, 2012.

## ABSTRACT

According to Figley (1995) there is a cost to caring and professional carers who listen to the traumatic accounts of others' emotional pain and suffering may feel similar suffering. The purpose of this phenomenological qualitative research study is to explore counsellors' experience of possible compassion fatigue. For the purpose of this investigation semi-structured interviews were conducted as a method of data collection. The constant comparative method was utilised to analyse the data. Findings reveal that despite the overlap, ambiguity and critique found between the terms and components all participants in this study experienced impact or signs that relate to aspects of the compassion fatigue spectrum. Six main categories were identified relating to the: impact, causes, supervision and support, training and continuing professional development, counsellor self-care, and finally issues that arose during counsellors' reflection following the research interview. Counsellors experienced impact of behavioural, cognitive, emotional and somatic nature, having sense of doubt and issues related to attachment and detachment. Positive impact was experienced by counsellors relating to compassion satisfaction and personal growth. A variety and combination of perceived causes were identified. Positive and negative experiences of supervision and support and training and continuing professional development were experienced. Counsellors' self-care included methods of distraction, balance and self awareness as being important for the prevention and amelioration of compassion fatigue. Upon reflection counsellors identified a number of significant issues including organisational responsibility for staff welfare, working conditions, employment and financial security.

## DECLARATION

“The work is original and has not been submitted previously in support of any qualification course.”

Signed: .....

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## LIST OF ABBREVIATIONS

|      |   |
|------|---|
| ACA  | American Counseling Association                       |
| AIDS | Acquired Immunodeficiency Syndrome                    |
| APA  | American Psychological Association                    |
| ARP  | Accelerated Programme for Compassion Fatigue          |
| BACP | British Association for Counselling and Psychotherapy |
| CBT  | Cognitive Behaviour Therapy                           |
| CPD  | Continuing Professional Development                   |
| CSDT | Constructivist Self Development Theory                |
| DSM  | Diagnostic and Statistical Manual of Mental Disorders |
| HIV  | Human Immunodeficiency Virus                          |
| NHS  | National Health Service                               |
| PTG  | Posttraumatic Growth                                  |
| PTGI | Posttraumatic Growth Inventory                        |
| PTSD | Posttraumatic Stress Disorder                         |
| STS  | Secondary Traumatic Stress                            |
| STSD | Secondary Traumatic Stress Disorder                   |
| VT   | Vicarious Traumatization                              |



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## 1. INTRODUCTION

During my earliest years of counselling clients who had experienced abusive trauma in childhood, there were times when I became rather clinical, anxious and overprotective of family members. My sleep patterns were disturbed and I felt socially isolated. I kept these experiences and others, as described in Appendix 1, to myself, trusting that the phase would pass and I would reach equilibrium. Reflecting upon this encounter inspired me to use my experience as a focus for this research, to gain a personal understanding and greater awareness that could be shared with other professionals.

The meaning of compassion is to bear suffering and according to Figley (2002b) the act of being compassionate and empathic can reduce capacity or interest in bearing the suffering of others. Figley (1995) believes there is a cost to caring and explains that professionals who listen to clients' accounts of fear, pain and suffering may feel similar fear, pain and suffering because they care and that those who have an enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress. Compassion fatigue, secondary trauma stress or secondary traumatisation, secondary stress disorder and vicarious traumatisation are found to be used interchangeably in psychotherapy literature (Figley 1995; McCann & Pearlman, 1990; Rothschild, 2006) and are generally related to the extreme affects upon the therapist within the psychotherapeutic relationship of hearing traumatic material from their clients. Rothschild (2006) however notes that compassion fatigue and burnout can also arise independently of the issues clients bring to therapy, such as workplace administration and

therapists' neglect to satisfy human needs for companionship, rest, reasonable working hours, free time and holidays amongst others.

The purpose of this phenomenological qualitative research study was to explore counsellors' experience of possible compassion fatigue. I invited counsellors who believed they may have experienced compassion fatigue to participate in the study by engaging in person to person research interviews. For those counsellors who expressed an interest to participate I provided brief information regarding compassion fatigue based upon Figley (1995, 2002a).

This study makes no attempt to diagnose the experience of individual participants, attribute any cause or advise. The intention of the study was to provide an arena for each participant's story to be heard and present a true account of their experience. For this purpose my intention was to use the process of '*epoche*' (McLeod, 2011) or bracket off my personal experience, interpretations and knowledge learned from text and to avoid bias whilst collecting and analysing the data. I utilised the Constant Comparative Method of data analysis (Glaser & Strauss, 1967). Counsellor and therapist are used interchangeably.

In addition to meeting requirements of a Masters Degree in Counselling Studies, my hope for this research study was to increase personal awareness, theoretical knowledge and professional skill as a counsellor. By contributing to existing research studies of similar focus (Ashcroft, 2001; Watkin, 2004) my intention is to

raise awareness of compassion fatigue and invite therapists and organisations to be mindful of the phenomenon.

## 2. LITERATURE REVIEW

### 2.1 Introduction

This literature review begins with background information including concepts and components of compassion fatigue. Examples of impact and possible causes of compassion fatigue are covered. Thereafter proposed methods of prevention, amelioration and recovery, including concepts of supervision and support, self care, counsellor training and continuing professional development are reviewed. Detailed search strategy is found in Appendix 5.

### 2.2 Background

Hosking (2007) defines compassion as: a feeling of closeness, with and a desire to help. According to Figley (1995) there is a cost to caring and professional carers who listen to the traumatic accounts of others' emotional pain and suffering may feel similar suffering. The term *compassion fatigue* was first used by Joinson (1992) when discussing nurse burnout and continues to be experienced by nurses as reported by researchers such as Austin, Goble, Leier & Byrne (2009). Figley (1995, pp7) identified secondary traumatic stress (STS) as being *the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other – the stress resulting from helping or wanting to help a traumatised or suffering person*. Figley described patterns of burnout and secondary victimization within families when an individual's trauma becomes contagious among the family members who may become exhausted or traumatised by the concern and empathic engagement they provide to the traumatised individual.

Earlier works of Figley (1978, 1985, 1986) focused upon the consequences of traumatic events, the diagnosis and treatments of posttraumatic stress disorder (PTSD) and the powerful systems of recovery within the networks of families, work groups, clubs and client-therapist relationships. PTSD is defined in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) (APA 1994) as a treatable psychiatric disorder. The symptoms of Secondary Traumatic Stress Disorder (STSD) are nearly identical to PTSD except that with STSD the symptoms are related to exposure or knowledge about a traumatizing experience of another person. PTSD symptoms relate directly to the person who has experienced a traumatic event (Figley 2002a). This symptom similarity is reflected in the DSM-III (APA 1994) for PTSD as to what constitutes a sufficiently traumatic experience which includes *learning about unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associates* (Criterion A1).

Figley (1995) replaced secondary traumatic stress and secondary traumatic stress disorder with his preferred terms: compassion stress and compassion fatigue and defined compassion fatigue as, *a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient* (Figley, 2002a pp 1435).

Compassion fatigue encompasses the concepts of burnout, emotional contagion, secondary victimization and traumatic countertransference (Figley 1995, 2002b). Secondary trauma and burnout are considered to be different (Figley 2002b), each

having their unique impact upon the professional's wellbeing (Jenkins & Baird 2002; Sabin-Farrell & Turpin 2003; Salston & Figley 2003). However it is acknowledged that secondary trauma and burnout are both characterised by the emotionally exhausting nature of working with traumatised people (Figley 1995, 2002b; Jenkins & Baird 2002; Schauben & Frazier 1995). Adams, Boscarino & Figley (2006) acknowledge the overlap between secondary trauma and burnout and attempt to differentiate the symptoms through their validation study. They conclude that the compassion fatigue therapists can suffer from contains two components: secondary trauma and job burnout. Although focused upon nursing Coetzee & Klopper (2010) observe the ambiguity of the term compassion fatigue noting much of the literature includes unique aspects of vicarious traumatisation, burnout and traumatic countertransference in their definition of compassion fatigue and that more often compassion fatigue is referred to as secondary stress (Stamm, 1999a). They identify that compassion fatigue progresses from compassion discomfort to compassion stress and finally to compassion fatigue, and if not eradicated in the discomfort and stress stages can permanently alter compassionate ability of the nurse. Bride (2007) reports that social workers in direct practice are likely to be secondarily exposed to traumatic events with many experiencing some symptoms of STS and a significant minority meeting the diagnostic criteria for PTSD.

Vicarious traumatisation (VT) is a related construct to compassion fatigue and secondary traumatic stress (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b). Vicarious traumatisation is when a transformation in the therapist's inner experience occurs resulting from empathic engagement with clients' trauma material (Saakvitne, Pearlman, and the Staff of the



Traumatic Stress Institute, 1996). McCann & Pearlman's (1990) Constructivist Self-Development Theory (CSDT) provides a model for understanding the psychological needs and cognitive schemas of trauma therapists. They identify that therapists may experience disruptions in their schemas about self and world which may be associated with their sense of safety, trust, power, esteem, intimacy and frame of reference. Therapists' unique reactions and type of disruption will depend upon the salience of schemas to the individual. Therapists may experience painful images and emotions associated with their clients' traumatic memories and eventually incorporate these memories into their own memory systems which can result in suffering from symptoms of PTSD.

Saakvitne (2002) relates to the multiple levels of vulnerability to traumatisation for the therapist when client and therapist share a traumatic event. Saakvitne (2002) warns against the tendency for therapists to emphasise the intellectual over the emotional and spiritual in their process and have unrealistic expectations regarding professional detachment and neutrality.

Maslach (1976) and Pines and Aronson (1988) identify burnout, being "*a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations*". Maslach and Jackson (1981) measure emotional exhaustion, depersonalization and reduced personal accomplishment as impact of burnout. Pines & Aronson (1988) however measure impact relating to physical exhaustion, emotional exhaustion, and mental exhaustion. Burnout differs from compassion fatigue, STS and VT by the slower onset and longer recovery which Figley (2002a) believes may require job or career change.

## **2.3 Impact**

Figley (1995) observes therapists' impact of compassion fatigue such as sadness, depression, sleeplessness and general anxiety. Impact is defined as being: cognitive, emotional, behavioural, spiritual, relational, somatic, work performance related and incorporating burnout, collated more extensively in Table 1 (Appendix 2). Dutton and Rubinstein (1995) categorise STS reactions in three areas; psychological distress or dysfunction, changes in cognitive schema and relational disturbances. They provide examples of psychological distress and dysfunction which are shown in Table 2 (Appendix 3).

Wilson & Thomas (2004) report impact of empathic strain upon therapists falling into five factors: intrusive preoccupation with the nature of trauma work experiences; avoidance and detachment; over-involvement and identification; professional alienation; and professional role satisfaction.

Changes in cognitive schema include beliefs, expectations, and assumptions (Janoff-Bulman, 1992; McCann & Pearlman, 1990); seeing everyone as victim (Courtois, 1988); "witness guilt" (Herman, 1992a) or "clinician guilt" (Silver, 1986) with Herman (1992a) also identifying "victim blame." Witness guilt and blame may be acted out by therapists in various responses including failing to recognise traumatic responses or distancing from difficulties such as multi-personality disorder (Dutton & Rubinstein 1995). Difficulty with trust and intimacy may affect therapists' personal relationships (Boylin & Briggie, 1987). Over-identification with clients resulting in detachment (Courtois, 1988) may protect therapists' emotional response to trauma but maintain clients' emotional isolation and lack of empathic

understanding (Dutton & Rubinstein 1995). Sensations such as dread, for example therapists secretly hoping clients will not attend a session, are noted by Berger (2001).

Rothschild (2002, 2006) highlights the impact of client's trauma upon the therapist's brain and body through the somatic nervous system. Berger (2001) suggests somatic symptoms felt by the therapist may be communication of the client's trauma material before any verbal disclosure by the client.

Paradoxically the impact of compassion satisfaction appears to reduce the risk of compassion fatigue (Collins & Long, 2003; Figley, 2002a, 2002b; Stamm, 2002; Steed & Downing, 1998) and may act as an ingredient to promote posttraumatic growth for therapists (Radey & Figley, 2007). The concept of posttraumatic growth, also referred to as stress related growth (Park, Cohen & Much, 1996) and adversarial growth (Linley & Joseph, 2004), reflects the philosophy of Frankl (1985) and the humanistic psychology of Rogers (1951). Posttraumatic (PTG) is a phenomenon relating to the opportunity for positive outcomes following trauma events (Murphy, 2009; Tedeschi & Calhoun 1995, 1996; Triplett, Tedeschi, Cann, Calhoun & Reeve, 2011; Shakespeare-Finch & Enders, 2008), can be observed by significant others and identified using the Posttraumatic Growth Inventory (PGTI) (Tedeschi & Calhoun, 1996) or the CSDT (McCann & Pearlman, 1990) as preferred by Sakvitne, Tennen & Affleck (1998). Five domains have been identified: greater appreciation of life, closer relationships, new possibilities, increased personal strength and spiritual change (Tedeschi & Calhoun 1996; Thompson, 1985; Woodward & Joseph, 2003). Berzoff & Kita (2010) report the profound satisfaction

of entering into an intimate space with a dying client, highlighting the importance of living for the therapist. Sanderson (2006) acknowledges the reward, pleasure, satisfaction and personal and professional growth as a result of being connected and having contributed to clients' healing and restored sense of self. Pearlman & Saakvitne (1995a, 1995b) highlight the significant and unique depth of intimacy shared in the therapeutic relationship and the positive impact the work has upon therapists. Mature and seasoned practitioners and use of evidence-based practices were significant predictors of compassion satisfaction and reduced compassion fatigue and burnout (Craig & Sprang, 2010; Cornille & Meyers, 1999; Meldrum, King & Spooner, 2002; Shah, Garland & Katz, 2007; Wee & Meyers, 2002).

Vicarious resilience (Hernandez 2010; Hernandez, Gangsel & Engstrom 2007; Wicks 2008) acts as a counterbalance to the negative impact of trauma work on therapists. Self-care, mindfulness and positive psychology is advocated for the creation of resilience and prevention of secondary stress. Wicks (2008) claims that the absence of therapist resilience leaves a void that is likely to be filled with secondary stress and fatigue, promoting the benefits of a self-care protocol.

## **2.4 Causes**

Rogers (1951, 1957) considers empathic understanding to be one of the core conditions for a therapeutic alliance and healing for the client. Rothschild (2006) hypothesises therapists may suffer as a result of unconscious empathy that is outside of therapists' awareness and control and interacts with the body, mind and brain. Figley (1995, 2002a, 2002b, 2004) sees empathic engagement as the driving force to an effective therapeutic alliance that requires the full resources of the

therapist's "self." The cost of having such an empathic response results from the emotional energy consumed in being exposed to clients' trauma and may result in the therapist experiencing trauma emotions of the client. This process is beneficial to the client's recovery but can have a detrimental effect on the therapist's immune system and quality of life. According to Wilson & Thomas (2004) trauma therapists require the skill and capacity of using empathy to *access the inner scars of the psyche and the organism itself*, which requires preparedness for significant and sure risk of empathic distress, affect deregulation, compassion fatigue, burnout, counter-transference processes and trauma states.

Figley (2002a) recognises the risks of compassion fatigue are also attributed to prolonged exposure to trauma clients, therapist's memories of personal past traumas being provoked and therapist's current life disruptions. Craig & Sprang (2010) observe that the percentage of PTSD clients in the therapist's case-load may contribute to compassion fatigue and secondary traumatic stress.

Kanter (2007) argues that worker stress has been explored for decades, particularly in the psychoanalytic world, identifying diverse causes, preventions and remedies that extend beyond those identified in the context of compassion fatigue. Kanter (2007) further contends the traumatic origins of worker stress are oversimplified and not solely related to exposure to trauma material but also difficulties of working with the chronic nature of alcoholism, substance misuse, severe mental illness and others. Deighton, Gurrus & Traue (2007) make similar contentions reporting higher levels of fatigue in therapists who, although advocated working through trauma, did not succeed due to hindrances such as unfavourable conditions and therapist

insecurity. Fear avoidance for both therapist and client can reinforce and maintain anxiety (Deighton, Guris & Traue, 2007). Meldrum, King and Spooner (2002) observe that role complexity and ambiguity are recognised as significant work stressors.

Vicarious traumatisation results from empathic engagement with traumatised clients (McCann & Pearlman 1990; Pearlman & Saakvitne, 1995). According to Maslach (1974) burnout is caused by long term involvement in emotionally demanding situations. Lee, Cho, Kissinger & Ogle (2010) assessed counsellor burnout using the Counsellor-Burnout Inventory based upon the dimensions of: exhaustion, incompetence, negative work environment, devaluing client and deterioration of personal life. They identified clusters in types of burnout: well-adjusted, persevering and disconnected counsellors.

Therapists working with clients suffering from the affects of trauma can include victims of disasters, violence, rape, incest, and child abuse (McCann & Pearlman, 1990). Copenhall (1995) identifies stress and post-traumatic stress disorder being encountered by therapists due to the excessive demands and pressures of working with clients who experience the long-term effects of childhood sexual abuse. Sanderson (2006) acknowledges that this work may lead to secondary traumatic stress, vicarious trauma, negative transference reactions, compassion fatigue and burnout with impact including loss of trust in the world and relationships and feelings of anxiety, inadequacy, becoming overprotective and isolated. Schauben & Frazier (1995) and Steed & Downing (1998) also note therapists' emotional disturbance.

Other origins of client trauma have been noted such as HIV/AIDS (Smith, 2007), although not widely researched and spiritual abuse (Gubi & Jacobs, 2009). Collective trauma can be experienced as a consequence of terrorist attacks also resulting in an increase of secondary trauma within the mental health profession (Adams, Boscarino & Figley, 2006; Boscarino, Figley, & Adams, 2004). Figley's earlier work (1978) focussed upon combat stress with Vietnam War veterans which Tyson (2007) notes may become more prominent with increasing combats such as Iraq and Afghanistan, posing greater risk of developing compassion fatigue for trauma therapists.

## **2.5 Supervision and Support**

Supervision is perceived by counsellors to be beneficial for reasons including: addressing professional isolation, support, emotional well-being, stress reduction and burn-out prevention (Mahon & Patton, 2000). Although Lawton & Feltham (2000) predict little correlation between supervision and client outcome, they believe it might ensure that counsellors are in better psychological shape.

Regular supervision with an experienced trauma-therapy supervisor is essential to therapists' self-care and ethical commitment to clients (Pearlman & Saakvitne, 1995), although Pearlman & Mac Ian (1995) reported 53% of trauma therapists receiving trauma-related supervision. According to Meldrum, King & Spooner (2002) supervision can provide clarity for case managers with complex and ambiguous roles which may guard against symptoms of STS, and reported that only 22% of mental health workers had rarely or never received sufficient, regular supervision.

A supportive environment allows therapists to talk and release emotions about clients (Meyers & Cornille, 2007) which according to Etherington (2000, 2009) if not addressed in supervision may accumulate over time with therapists becoming tired, stressed, less able to help their clients and themselves and vulnerable to VT. Wee & Myers (2002) claim supervision can detect blind spots, correct over-identification and analyse over-involvement. Needs of therapists can be monitored, particularly those having experienced trauma and/or newer to the profession, helping guard against therapists becoming overwhelmed with personal and professional roles becoming blurred. Wheeler (2007) refers to the *wounded healer* and how untangling complexities of counter-transference responses in the therapeutic relationship is only possible in a secure supervisory relationship where therapists' vulnerability is respected.

Supervisors need a sound knowledge of trauma theory (Etherington 2000, 2009) to help counsellors disentangle complexities of the therapeutic relationship. Supervisors have a responsibility to use their knowledge and provide a CT-preventative environment (Trippany, White, Kress & Wilcoxon, 2004). Additionally having knowledge of child development and attachment theory, ability to work with complex counter-transference, an awareness of secondary traumatisation and symptoms of PTSD helps supervisors detect STS (Walker, 2004). It may be appropriate for some therapists who are distressed to take time out of work, although King and Wheeler (1999) reported that supervisors were reluctant to give this advice to therapists.



Peer support groups are advocated for the prevention and amelioration of compassion fatigue, STS and VT (Catherall, 1999; Meyers & Cornille, 2007; Pearlman & Mac Ian, 1995; Rosenbloom, Pratt & Pearlman, 1995; Yassen, 1995) where group discussion, debriefing, information exchange and support can act as a vehicle to enhance self-care (Barlow & Phelan, 2007).

## **2.6 Self-care**

Self-care skills are necessary for addressing and transforming VT (Saakvitne, 2002). Peer support, case-load balance and work/life balance; boundaries and realistic expectations of self and others; self awareness, particularly of unresolved personal traumas are advised (McCann & Pearlman, 1990). Saakvitne & Pearlman (1996) advocate mindfulness and acceptance as effective components of their self-care intervention strategy (Table 3, Appendix 4) that thread through three realms of the therapist's life: professional, organisational and personal.

Counsellors engaging in self-care activities report lower levels of compassion fatigue and higher levels of compassion satisfaction (Alkema, Lindon & Davies, 2008). Rest and activities that are creative, physical and social are recommended by Pearlman (1995). Humour is noted as a means of distracting, diverting, gaining a sense of balance and perspective (Weiss, 2004), a resource for connecting with life and disconnecting from the pain of trauma (Yassen, 1995). Danieli's (1994) three stage recovery model consists of the following: recognising personal feelings and responses to distress; recognising and containing own vulnerabilities and limitations knowing that responses have a beginning, middle and end; and taking breaks, annual leave and managing client case load. O'Halloran & Linton (2000) offer a

resource bibliography that covers six domains of self-care strategies: social, emotional, cognitive, physical, spiritual and vocational. Having a strong sense of spirituality offers a coping mechanism for managing and alleviating the impact of trauma work (Pearlman & Saakvitne, 1995b; Pearlman & Mac Ian, 1995; Astin, 1997) and helps counsellors accept existential realities and as a result be more present with their clients (Wittine, 1995).

The practice of self-compassion promotes wellness and alleviates therapist stress (Barnett, Baker, Elman, & Schoener 2007; Mahoney 2005), helps lower unrealistic self-expectations and develop effective boundaries between client's needs and counsellor's needs (Patsiopoulos & Buchanan, 2011). Mindfulness practice can enhance counsellors' physical and psychological wellbeing, help prevent compassion fatigue, increase self-awareness, contain emotion and enable more openness and less defensiveness in supervision (Christopher & Maris 2010; Schure, Christopher & Christopher, 2008). Richards, Campenni & Muse-Burke (2010) observe that mindfulness may enhance well-being for some, but invite others to focus upon negative areas of their lives, causing a decrease in wellness.

Daw & Joseph (2007) note that therapists engage in personal therapy primarily to provide self care and manage personal distress. Stebnicki (2007) believes having a clear understanding about the risk of empathy fatigue is pivotal for adopting self-care strategies that promote resiliency and well being for counsellors.

Rothschild (2002) invites therapists to monitor anxiety in their body, and by applying techniques of *putting on the brakes* helps prevent high levels of arousal that can

impair therapists' cognitive ability and concentration. The ability to help with clients' distress is therefore compromised. Rothschild's (2006 pp.192-194) self-care strategy includes what to monitor and do during, between and after counselling sessions. Utilising their *Coping Strategies Inventory* Bober, Regehr & Zhoe (2006) reported time spent on leisure, self-care, supervision and research and development as means of reducing stress in trauma counsellors.

## **2.7 Training and Continuing Professional Development**

Training in trauma therapy (Adams & Riggs, 2008, O'Halloran & O'Halloran, 2001, Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Salston & Figley, 2003), components of compassion fatigue (Cambell, 2007; Figley, 2002a, 2002b) clinical skills (Kanter, 2007) and theory (Pearlman & Saakvitne, 1995a, 1995b; Schauben & Frazier, 1995; Steed & Downing, 1998) are advocated.

Roach & Young's (2007) philosophy of wellness within counsellor education is supported by Sommer (2008) who states that educators have an ethical responsibility to prepare counsellors and supervisors to detect and resolve VT. American Counseling Association's (2005) *ACA Code of Ethics* and Council for Accreditation of Counseling and Related Educational Programs' (2007) proposed standards, relate to trauma counselling and vicarious traumatisation. British Association for Counselling and Psychotherapy (2009) *BACP Ethical Framework for Good Practice in Counselling & Psychotherapy* interestingly makes no specific reference to vicarious traumatisation with regard to *teaching and training*; however reference is made within the nine components of *professional moral qualities*, such as resilience and competence.

Fahy (2007) and Campbell (2007) conclude that therapists have a personal responsibility to implement interventions for the prevention of compassion fatigue that include education, supervision, wellness programmes and to seek and accept assistance from others when necessary.

## **2.8 Conclusion**

This literature review highlights the history, definitions and spectrum of compassion fatigue mainly focusing upon the work of Figley. The related constructs of vicarious traumatisation (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b Saakvitne, 2002) and burnout (Maslach, 1976; Pines & Aronson, 1988) are also reviewed, identifying the interrelated components of each. The review reveals the range of impact upon therapists and causes of this phenomenon upon therapists as identified by the authors. It also examines methods of prevention, amelioration and recovery, including supervision and support, therapist self-care, and training and continuing professional development.

### **3. METHODOLOGY**

Research methodology is a philosophical framework that enables the researcher to link the topic of enquiry, or research question, to a rigorous set of procedures that travel from generating data to data analysis, providing an audit trail that validates the findings (Maykut & Morehouse, 1994).

#### **3.1 Research Philosophy and Design**

When deciding which research methodology was best suited to the subject of my enquiry I considered two options. Quantitative Research is the traditional or “old” paradigm research methodology that provides a positivist approach to an objective, scientific inquiry that assumes there is a single reality (Makut & Morehouse, 1994). Collection of numerical data exists independently and without influence from the researcher (Denscombe, 2010). Quantitative research methods are underpinned by the positivist approach and are deductive in that they test theories that have already been proposed and measure outcomes using statistical analysis (McLeod, 1999). Statistical analysis of numbers provides reliability and validity and enables accuracy in measurement (Barker, Pistrang & Elliott, 1995). Quantitative research lends itself to larger scale research with greater numbers and quantities (Denscombe, 2010).

A new paradigm of research described by Reason & Rowan (1981) was developed to conduct a humanistic inquiry based upon a social constructionist perspective (Gergan, 1985; 1994). The new paradigm relates to Qualitative Research Methods that seek to find patterns of meanings relating to human behaviour, thoughts and

feelings, having a holistic perspective. Qualitative Research tends to have more involvement from the researcher in the construction of the data (Denscombe, 2010). Phenomenology is the philosophy, which largely underpins the new research paradigm and includes a number of research methodologies, such as heuristic, narrative, grounded theory, and phenomenological methods (McLeod, 1999). Phenomenology is related to humanistic research using qualitative research methodologies that hold special importance to individual's beliefs, personal experiences, feelings and emotions (Denscombe, 2010). Phenomenological research methodology provides the researcher with a set of process procedures that elucidates the essence of the phenomenon being studied as it exists in participants' concrete experience (McLeod, 2011).

A qualitative approach was chosen for this study because it allowed me to explore and discover the meaning of the phenomenon of compassion fatigue as experienced by individual therapists. I did not wish to pursue a study of measurement of variables or adopt a detached objective stance to the collection of data but to collaboratively co-construct knowledge, give place to reflexive self awareness as researcher (McLeod, 1999) and understand participants' perception and interpretation of the phenomenon through their spoken word and phrase.

Acknowledging participants as agents I wished to gain knowledge from other counsellors' experiences and interpretations of the phenomenon that may be general in nature, but more importantly unique in their personal perception, producing a deeper understanding of the phenomenon rather than a generalisation (Lincoln &

Guba, 1985). Phenomenological research methodology was therefore chosen for this qualitative research study.

As researcher I immersed myself into the research process, aware of the interdependence between the knower and the known (Maykut & Moorehouse, 1994), I wanted to explore the phenomenon from as neutral a perspective as possible allowing all perspectives to be understood. For this purpose I utilised the process of '*epoche*,' otherwise known as bracketing, a phenomenological reduction (McLeod, 2011) which required me to set aside and/or be aware of my prejudices, assumptions and beliefs about the phenomenon so as not to impose meaning or prejudgment and be able to observe with a fresh open view (Maykut & Morehouse, 1994). McLeod (2011) describes '*epoche*' as necessary discipline that takes time to master.

I followed the path of Maykut & Morehouse (1994) and adopted their practice of indwelling for the duration of the study, making my role as researcher a paradoxical one, having to be closely tuned to participants' experience and interpretations of the phenomenon, the indwelling; and being aware of and how my personal preconceptions and beliefs may influence what I was trying to understand.

### **3.2 Sample**

Probability sampling and non-probability sampling were the two approaches I considered before deciding which sample selection method to be used for this small scale research. Probability sampling is based upon statistical theory and is best used with large numbers for larger scale research when the target population is

known and the sample will be representative of the population. Probability samples can be randomly selected without the bias or influence of the researcher (Denscombe, 2010).

Non-probability sampling is not based upon random selection and was chosen because it was not possible to include large numbers in this small scale study and certain criteria needed to be met by people selected for the topic of enquiry (Denscombe, 2010).

I chose a 'purposive sample,' selected from an identified group of counsellors who met the criteria relevant to the research topic and were likely to produce the most valuable and variable data (Denscombe, 2010). I followed the guidance of Silverman (2005) and thought critically about the parameters of the population I chose to study and was prepared to select the sample carefully.

Due to the realistic limitation of resources, I proposed that a maximum of eight participants would be selected as large sample numbers make it difficult to conduct sensitive and intensive quality research analysis (McLeod 1999).



The following criteria and rationale was used for selecting participants:

**Inclusion Criteria**

- **Counsellors who believed they may have experienced compassion fatigue**

**Rationale**

I did not wish to assume the role of diagnosis or presume that counsellors have experienced compassion fatigue. Therefore there is an emphasis upon the phrase ***believed they may have experienced compassion fatigue.***

I wished to respect respondents' reason for agreeing to participate in the study particularly regarding the fact that for some respondents they may not have been aware what their experiences related to.

- 
- **Counsellors with a minimum of four years counselling experience**

I wanted to make sure that counsellors were established in their practice and had sufficient professional experience to reflect upon.

- 
- **Counsellors who are currently in supervised practice**

My aim was to adhere to ethical practice and ensure that participants accessed supervisory support, particularly regarding the sensitive and emotive nature of the topic of enquiry.

I considered that counsellors in current supervised practice would be familiar with modern therapeutic culture and community.

- 
- **Counsellors who have access to personal therapy**

My aim was to adhere to ethical practice and the self-care of participants.

When inviting participants to reflect and talk about their experience of compassion fatigue I was being mindful of the sensitive and emotive nature regarding the topic of enquiry.

I wished to promote self care and ensure that sufficient support would be available for participants if required.

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| <b>Exclusion Criterion</b>  | <b>Rationale</b>  |
|---|---|
| <ul style="list-style-type: none"> <li><b>Counsellors who believed they may currently be experiencing compassion fatigue</b></li> </ul> | As an ethical issue and duty of care I did not wish to invite counsellors who believed they may currently be experiencing compassion fatigue. |

With the aim of inviting counsellors to participate in this research study I designed an advertising poster (*Appendix 6*) and disseminated copies to counselling organisations, agencies, forums and Counselling Departments of Higher Educational Institutions within a radius of approximately 60 miles of my home town. An advertisement (*Appendix 7*) was also placed in the British Association for Counselling and Psychotherapy (BACP) journal, '*Therapy Today*.'

Letters and research information packs were sent to the twelve interested responders. Each information pack consisted of:

| <b><u>Document</u></b>                                       | <b><u>Appendix</u></b> |
|--|------------------------|
| Letter to respondents  | Appendix 9             |
| Research Information Leaflet                                 | Appendix 10            |
| Research Preliminary Questionnaire                           | Appendix 11            |
| Informed Consent to participate document                     | Appendix 12            |
| Informed Consent to audio record research interview document | Appendix 13            |

The preliminary questionnaire (*Appendix 11*) provided profile information for each participant which may also have influenced the selection process should there have been an abundance of consenting participants and variation was preferable. Participant profiles are found in Table 4.

**Table 4. Participant Profiles**

| Participant   | B  | C  | D  | E   | F   | G  |
|---|--|--|--|---|---|--|
| Gender  | Female   | Male   | Female   | Male  | Female  | Female   |
| Years of counselling experience   | 11   | ?  | 7  | 11  | 20  | 7  |
| Knowingly experienced compassion fatigue  | Yes  | To a limited degree  | To a considerable degree   | Don't know  | Not knowingly   | To a considerable degree   |
| Theoretical model of counselling  | Psychodynamic and introduce tools from other models  | Person Centred<br><br>Integrating Relational, CBT and Motivational<br><br>Systems and Psychodynamic                            | Person Centred<br><br>CBT  | Person Centred<br><br>CBT   | Eclectic<br>Jung, Gestalt, NLP, Psychodrama and Constellation work  | Integrative<br><br>Person Centred<br><br>CBT   |
| Counselling environment   | Private Agency (Hospice)   | Voluntary Agency (Drug and alcohol addiction)  | Private Practice Agency (Hospice)  | Voluntary Agency<br><br>NHS   | Private Practice Agency   | Private Practice Agency  |
| Hours of face to face counselling provided per week   | 6 (approx.)  | 14<br><br>Plus 4 group therapy   | 16 – 20  | 10  | 18  | 20   |
| Duration or length of therapy provided  | Open ended   | Brief<br><br>Longer Term   | Brief<br><br>Longer Term   | Brief<br><br>Long Term  | Brief<br><br>Open Ended   | Brief<br><br>Longer Term   |
| Range of client problems  | Bereavement related issues including: melancholic symptoms, fatigue, despair, suicide and self-harm tendencies | Rape and Sexual abuse Trauma, Domestic violence, Bereavement, Loss of children, Mental illness – Depression, anxiety, Recovery | Bereavement, Depression, Anxiety, End of life preparation, Coping with diagnosis, prognosis and physical deterioration | Depression<br>Anxiety, Effects of abuse, Relationship problems, Stress, Low self esteem, Coping with illness, Trauma, Alienation, Withdrawal caused by torture and seeking asylum | Anxiety, Repeated behavioural and relationship patterns, Childhood trauma, Phobias, Somatic patterns, Smoking / Weight / Eating problems, Inter family issues | Emotional/ Psychological issues<br><br>Work-place stress<br><br>Adult survivors of abuse |
| Nature of specialised service   | Grief and complex grief  | Drug addiction causes, recovery and rehabilitation   | Cancer support<br><br>Depression   | Refugees/ Asylum seekers – tortured   | Anxiety and phobias   | Trauma work<br><br>Relational dynamics   |
| Brief Therapy = 0-12 sessions                                                             Longer Term Therapy – 12+ sessions                                                             Long Term Therapy = 24+ sessions |  |  |  |   |   |  |

### **3.3 Pilot Interview**

Pilot interviews, conducted with participants who give constructive feedback, offer an opportunity for the researcher to make any necessary amendments to participant instructions, interview guide, format and technical equipment (McLeod 2003; Rumsey & Marks, 2004). They also provide practice for the researcher to build confidence when collecting the data for analysis (McLeod 2003) and help refine and validate research questions (Dallos & Vetere 2005). Conducting a pilot interview gave me an indication of the length of time each interview would take. The pilot interview also allowed me to discover the natural flow of content of the interview. Beginning with a single open question inviting the participant to share their experience of the phenomenon, I was thereafter able to correlate the information with the prepared interview guide; I intended to use as an 'aide memoir' in subsequent interviews. The participant of the pilot interview also provided feedback of my interviewing style and personal benefit gained from the interview.

### **3.4 Data Collection**

For the purpose of this qualitative phenomenological research study I chose to conduct person to person interviews, a method of data collection which is compatible with the philosophy and aims of the study (McLeod, 2003; Maykut & Morehouse, 1994). Face to face interviews provided a source of rich data relating personal experiences and a greater understanding of the phenomenon.

Having previous experience of facilitating focus group interviews that offered participants an opportunity to jointly share experiences, the depth of experience shared was limited. Maykut & Morehouse (1994) consider that taking a moderator

role as researcher in a group interview may hinder the relationship between researcher and group members resulting in members feeling more like subjects in an experiment. Willig (2008) suggests that where subject matter is sensitive semi-structured interviews may be more appropriate as disclosure is not usually enhanced through the presence of other participants.

Qualitative interviewing formats are described as being structured, semi-structured or unstructured and on this continuum I chose a semi-structured interview format. Using an interview guide (*Appendix 14*) as an aide memoir, I invited participants to share their experience of the phenomenon, and the opportunity for a discussion that offered the maximum amount of detailed information. I believe having a person centred approach enabled me to establish a relationship with participants who according to Mearns & McLeod (1984) were more likely to engage with the research in an authentic and constructive manner. Maykut & Morehouse (1994) note that having a deep and genuine curiosity about understanding another's experience results in skilful qualitative interviews.

Interviews were arranged for dates and times that were convenient and at venues to suit the individual participant. I prepared an interview guide (*Appendix 14*) as an 'aide memoir,' consisting of opened ended questions. According to Barker, Pistrang & Elliott (1995) interview guides allow the researcher to prompt, probe or clarify when necessary. Interview guides also enable the researcher to balance the need for order with the liberty to explore unanticipated themes (Rubin & Rubin, 1995). My use of summarising enabled participants to clarify and verify my interpretation, an interview quality recognised by Kvale & Brinkmann (2009).

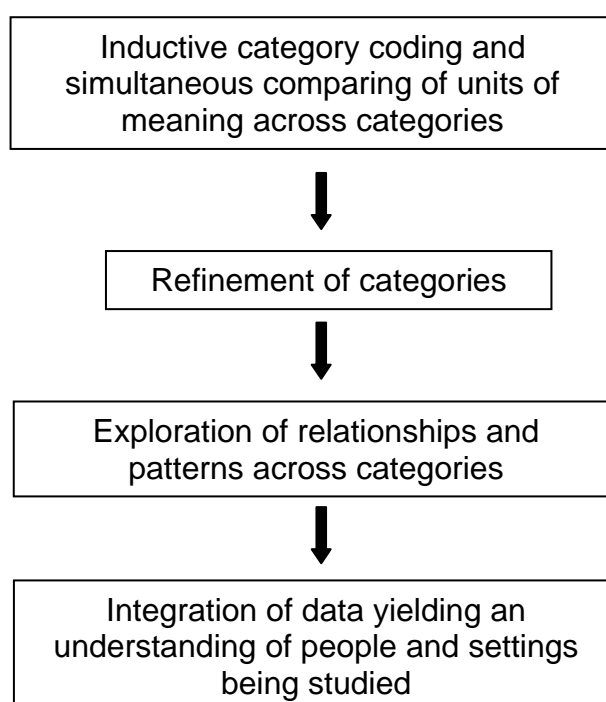
All interview audio recordings were transcribed with participants being provided with a copy of the transcription and invited to delete or amend any part of it before giving approval for the final data to be used for analysis.

### **3.5 Data Analysis**

To maintain authenticity, validity and transparency it is important to use a meticulous and systematic method of data analysis. For this reason I was guided by Maykut & Morehouse (1994) and utilised the constant comparative method of data analysis. This is a product of grounded theory which Glaser and Strauss (1967) developed and which Maykut & Morehouse (1994) and Lincoln & Guba (1984) consider being compatible with phenomenological research methodology. I engaged in a process of constantly comparing one data set with another in order to identify categories of meaning that explained and described the phenomenon, allowing the variation of themes to emerge from the data using inductive reasoning.

Makut and Morehouse (1994) describe a systematic process of four stages of the constant comparative method of data analysis as outlined in Table 5.

Table 5. Constant comparative method of data analysis (Maykut & Morehouse, 1994).



I quite naturally became immersed in the data whilst interviewing and transcribing interviews, noting comparison between content of one interview and another. I kept a research journal (*Appendix 15*) noting concepts, recurring themes and ideas as a first step to analysis (Maykut & Morehouse, 1994). Transcribing each audio recording was a lengthy process that provided me with a second opportunity to immerse myself in the verbal narrative, recalling particular emphasis upon words, silences that represented thoughtful reflection on behalf of the participant and their facial expressions. Transcribing enables the researcher to reflect on their interview style and revisit social and emotional aspects of the interview prior to analysis (Kvale & Brinkmann, 2009)

To prepare the raw data sets for analysis each transcription was systematically coded, with the code being printed on each page to act as an anonymous reference

point and to ensure a robust audit trail. To include member checks (Lincoln & Guba, 1985) participants were provided with a copy of their transcribed interview and asked to amend errors and/or delete any part of the data they did not wish to be used for analysis. Approved transcriptions were thereafter printed with line of script numbered and thereafter photocopied for analysis. Immersion continued whilst reading and re-reading the transcripts, which journeyed me to deconstruct the data by noting words and phrases, concepts, patterns and themes onto unitized index cards (*Appendix 18*) and discovery sheet (*Appendix 19*), allowing units of meaning to emerge (Maykut & Morehouse, 1994). All units of meaning were compared and grouped into provisional and final categories. 'Propositional statements,' or 'rules for inclusion' (*Appendix 20*) were assigned to each category providing an explanation of meaning contained in the data. This process of categorisation enables the meaning contained in the data to be integrated into a new synthesis that provides an understanding of the phenomenon (Maykut & Morehouse, 1994). During this lengthy period which I described as *travelling around the world and back*, I adopted the practice of incubation allowing the information to germinate before arriving at any conclusions. Consultation with my research supervisor was a valuable method of maintaining objectivity to prevent any personal bias from influencing the extraction of data.

### **3.6 Validity and Trustworthiness**

McLeod (2003) believes that validity of qualitative research should be judged on the basis of trustworthiness. Guba & Lincoln's (1989) judgment of trustworthiness consists of four components: credibility, transferability, dependability and confirmability.



To ensure the trustworthiness of this research study I used a standardised methodology and aimed to provide clarity regarding each stage of the research process. In choosing a qualitative phenomenological research study my aim was to obtain data that was rich in description of the subjective experience and be open to the possibility of multiple realities (Denscombe, 2010).

I sought and selected participants from a wide geographical range and professional profile, all of whom reported to have experienced possible compassion fatigue (see Table 4 for profile).

When conducting interviews I allowed for a free-flow of dialogue allowing participants to reflect upon their experience and summarised what they had told me to ensure clarity, accuracy and respect for them being heard. I responded to the personal meaning of each participant's experience by also acknowledging for example their tone and non-verbal communication.

The entire interview for each participant was recorded and fully transcribed so as not to lose any information relating to the research subject. To include 'member checks' (Lincoln & Guba, 1985) all transcriptions were verified by participants. Participants were advised they may have a copy of the final report if requested.

I aimed to provide an audit trail of each step of data analysis with all data being coded and cross-referenced so that the source of data may be located. I provided evidence of reasons for inclusion when identifying propositional statements and

subject categories, rather than anecdotes that do not provide a broader context (Silverman, 2010).

Stiles (1993) developed a set of criteria for evaluating qualitative data which I made reference to throughout the process. In terms of contextualising the study within historical, social and cultural setting I mindfully observed and noted open discussion, comments and references to fatigue within the counselling community, and conducted a literature review.

As the impetus for conducting this research study originated from a heuristic perspective I declared my personal experience, awareness and knowledge of the focus of my inquiry and any expectations I may have of the outcome. Although I used the process of bracketing, this declaration allows an openness of any possible bias I may bring to the study. I adopted a reflexive practice (Stiles, 1993, 1999) by keeping a journal (*Appendix 15*) recording my reflections of the process, providing transparency and hopefully the credibility of my work.

### **3.7 Ethical Issues**

Bond (2004) advises that ethical researchers seek to achieve the highest possible levels of trustworthiness and integrity in terms of the research relationship, the construction and communication of new knowledge and the application of research to practice.

McLeod (1999, 2003) notes that the main set of procedures in order to ensure that ethical standards are met when conducting qualitative research involving people are:

informed consent; confidentiality and avoidance of harm. Elmes, Kantowitz & Rosediger (1995) include informed consent, no deception, right to withdraw, debriefing and confidentiality as ethical considerations. It is recognised that signed informed consent is an essential ethical research procedure (Denscombe, 2010; McLeod, 2003; Silverman, 2010). However Lindsay (1984) warns is not always straightforward. I adopted Brinkmann & Kvale's (2008) philosophy of remaining ethically tuned throughout the research process so that any dilemmas arising could be responded to appropriately.

I conducted this research as a professional counsellor and member of British Association for Counselling and Psychotherapy (BACP) and bound by the *Ethical Framework for Good Practice in Counselling and Psychotherapy* (BACP, 2010) and the *Ethical Guidelines for Researching Counselling and Psychotherapy* (Bond 2004). I endeavoured to implement these recommendations into the research process and aimed to conduct the study with honesty, integrity, beneficence and non-maleficence towards the participants.

My first important undertaking was to obtain ethical approval following submission of a formal research proposal to the Ethics Committee of the University of Chester's Department of Social and Communication Studies. I thereafter consistently maintained contact with my research supervisor who was able to offer valuable guidance and monitor the project throughout.

In relation to integrity and trustworthiness in terms of the research relationship and avoiding risk of a dual relationship (Bond, 2004) I advertised and selected

participants from a wide geographical range and did not interview therapists who were known to me. The only exception was a pilot interview conducted with an interested colleague who, as previously mentioned, provided feedback regarding the questionnaires, information and interview process.

With regard to informed consent counsellors who expressed an interest in participating were provided with written information (*Appendix 10*) regarding the research study and an explanation of the process that participants would be asked to engage in. This information included details about the topic of inquiry, the interview process and that the interview will be audio recorded and transcribed by the researcher. Information regarding a complaints procedure was also provided. The six agreeing participants signed an 'informed consent to participate document,' (*Appendix 12*) with the option to withdraw at any time.

Prior to each interview participants were reminded of informed consent, liberty to withdraw and asked to provide informed signed consent for the interview to be audio recorded. The University of Chester, MA in Counselling Studies Research Consent Form for Audio Recording of Interview (*Appendix 13*) was used for this purpose. Copies of signed consent forms were retained by each participant and me as researcher.

Confidentiality is an important ethical and legal requirement of my work as a counsellor and which I applied to my role as researcher abiding by professional standards in terms of handling personal sensitive information (Bond 2004) and legal requirements in terms of the Data Protection Act (HMSO, 1998). Procedures were

undertaken during this research study to maintain anonymity and confidentiality whereby some content of data was removed, coding was utilised and identity of participants was kept separate from raw data. All electronic documents were saved with the use of high level password security. Audio and digital recordings will be securely stored until the completion of this Masters Degree Dissertation and will thereafter be erased. All other data such as transcriptions have been stored in a locked safe haven for a period of five years. Participants were advised of this procedure in the written information leaflet and verbally before the interview.

Due to the sensitivity of material explored and consideration to risk of any possible harm that might occur to participants I invited experienced counsellors with a minimum of four years post-qualified experience, ensuring that all participants were engaged in on-going professional supervision, respecting their integrity that they had access to personal psychological therapy if required. The purpose of this was to alleviate any possible distress that might have arisen from participating in the study. Wanting to be transparent and honest I provided an opportunity for each participant to debrief, give feedback and ask questions following their interview. In fact participants shared that they found the interview of personal value.

Each interview was carefully and faithfully transcribed with transcriptions being forwarded to each relevant participant so they had the opportunity to amend or delete as appropriate or withdraw if they so wished. According to The World Medical Declaration of Helsinki (2000) the wellbeing of human subjects must take precedence over scientific study.

Bond (2004) includes “researcher’s responsibilities to self,” as a feature of ethical research which I integrated into the study, being mindful of the possible impact the study would have upon me and accessing professional support and guidance throughout the process.

### **3.8 Limitations of the Study**

Validity may be questioned with regard to the sample population size as not being sufficiently significant to represent the population as a whole. This small-scale study is part of the requirements for a Masters Degree in Counselling Studies and as such is limited by the resources of myself as researcher. The variance was limited by the small sample population and having to exclude counsellors working in NHS settings that required additional research ethical approval that was beyond the resources of researcher. Straus & Corbin (1990) advise that the validity is improved when sample size is increased to reach saturation point.

I limited this research study to one methodology which prevented the process of triangulation to occur and which allows the research to be viewed from more than one perspective, improve accuracy and provide a fuller picture. Triangulation can be achieved by using more than one methodology, different data sources and more than one researcher (Denscombe, 2010).

Using a combination of quantitative and qualitative research methods did not seem an option for this research. I did not propose to test a hypothesis which quantitative, positivist research methods would provide using statistically correct sampling. It may have been interesting to discover what proportion of a counselling population

believed they have experienced compassion fatigue which would have contributed to the findings. However Knight (2002) advises that for social world research data obtained using positivism and hermeneutics cannot be blended as they produce results originating from different ontologies and epistemologies. I could have obtained data from an additional source using questionnaires, calling upon great demand from me as researcher and as Denscombe (2010) warns requires extra support and confident skill in order to support validity.

## **4. RESEARCH FINDINGS**

This research study explores counsellors' experience of possible compassion fatigue. Having completed analysis of the data from six participant person to person interviews six categories emerged with additional sub categories. The six categories and sub categories are:

### **1. How Counsellors experienced the impact of possible compassion fatigue**

- Counsellors experienced behavioural, cognitive, emotional and somatic impact of possible compassion fatigue
- Counsellors experienced having a sense of doubt about themselves as therapists, clients and the organisation
- Counsellors experienced impact of attachment and detachment issues
- Counsellors experienced satisfaction and a sense of personal growth

### **2. What Counsellors considered may contribute to the cause of possible compassion fatigue**

- Counsellors considered that personal factors may have contributed to their experience of possible compassion fatigue
- Counsellors considered that factors in relation to the client contributed to their experience of possible compassion fatigue
- Counsellors considered that issues in relation to the organisation contributed to their experience of possible compassion fatigue

### **3. How Counsellors perceived supervision and support during their experience of possible compassion fatigue**

- Counsellors had positive perceptions of supervision and support during their experience of possible compassion fatigue
- Counsellors had negative perceptions of supervision and support during their experience of possible compassion fatigue



**4. How Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue**

- Counsellors had positive and negative views regarding initial counsellor training
- Counsellors' views varied regarding continuing professional development training

**5. How Counsellors perceived self care in relation to their experience of possible compassion fatigue**

- Counsellors used forms of distraction as a method of self care
- Counsellors created a sense of work/life balance as a method of self care
- Counsellors valued self awareness initiatives

**6. Issues which arose during Counsellors' reflection following the research interview regarding their experience of possible compassion fatigue**

***Please note:*** In order to provide an audit trail and clear reference tool, all examples of data from transcriptions are referenced by code, for example:

Part-B:2:4 refers to Participant B, Page 2, Line 4

## 4.1 The impact Counsellors experienced from possible compassion fatigue

### Counsellors experienced behavioural, cognitive, emotional and somatic impact of possible compassion fatigue

During each interview counsellors described the different types of impact they experienced from possible compassion fatigue including behavioural, cognitive, emotional and somatic. Some counsellors referred to descriptions such as signs, signals or symptoms. For the purpose of this text the word impact will be used respectfully. The following shows examples of impact each participant experienced.

Participant B employed by a hospice organisation and worked mostly with bereaved clients, shared her sense of fear that what had happened to her clients could happen to her and experienced black thoughts.

*I'd start crying with relief that I hadn't come home and found him collapsed on the floor,... quite black thoughts ....*

Par-B-4:4

*I, at that point was feeling a bit out of control with it and feeling very down.*

Par-B:5:2

Participant C shared an awareness of stress, anger, irritation, feeling alone and projecting anger towards the client.

*I was feeling quite stressful, feeling quite angry and irritated .... with the client, thinking of the game that she was playing.... struggling to concentrate, pretty wound up....*

Par-C:2:18

*I did feel quite alone.*

Par-C:5:4

Participant D shared that she did not become emotionally moved as she used to, particularly with her family in terms of compassion, empathic response and

becoming more empirical. Participant D also noticed a loss of energy and a somatic impact which she believed is stress related and a loss of energy.

*....emotionally drained and almost fed up with having to be compassionate constantly.... And sometimes I just get worn out by it.*

Par-D:2:17

*....flatness really, a dead liner.... don't get moved by like I used to.*

Par-D:5:7

*If somebody came to me for counselling because he'd just had a cancer diagnosis I wouldn't be so clinical and so and so empirical and detached from it. I'd be empathising and be more compassionate.*

Par-D:6:9

*It's almost like I'm exhausted, fatigued, like an exhaustion, I'm exhausted by the compassion that I have to show, and because I have to show compassion then I get too exhausted to show it, it that makes sense.*

Par-D:13:20

*I've developed some kind of muscular disorder.*

Par-D:15:9

Participant E and F shared uncertainty whether their experience would be classed as compassion fatigue but they both observed change in energy levels, having a sense of irritation and Participant F being drawn into the client's world.

*I was so exhausted that I had to go to bed before 10-o-clock.*

Par-E:6:1

*I was irritable, .... after I'd had seen these two difficult clients and I was a bit snappy at home in the evening, I mean not, not major, but I was snappy.*

Par-E:38:3

*But if there's just a general sense that I'm running dry I think it's perhaps compassion fatigue.*

Par-F:1:19

*....more than anything else it tends to be a feeling of sleepiness .... So it is a sense of being in a trance when you're there and almost unable to move them forward, almost not being able to find the energy.*

Par-F:2:6

Participant G found the impact of working with children included needing a cool-off period after a counselling session, feeling upset, alone and helpless. This participant became more protective towards her son and again, similar to other participants, had depletion in energy although would sit up late at night and not focus on what she was watching on the television.

*I'd been quite upset, particularly were there'd been situations where there's a limit, and quite alone in it really, ....*

Par-G:2:12

*And just that sort of feeling of helplessness, ....*

Par-G:4:5

*....more kind of protective really with my own son.*

Par-G:5:2

*It was really draining.*

Par-G:6:18

### **Counsellors experienced having a sense of doubt about themselves as therapists, clients and the organisation**

Two counsellors experienced having a sense of doubt about themselves as therapists with Participant G also sharing that she questioned whether she wanted to continue in the profession.

*I questioned a bit of my practice I suppose as well really.*

Par-C:5:7

*I didn't even know whether I was helpful being there because of how I felt about it.*

Par-G:4:9

Participant C experienced having a sense of doubt about the client's ability to progress.

*I noticed it because I was making a lot of judgments and opinions of clients, what I was thinking of the client, how I was thinking with them and how they were progressing, if I was thinking quite negatively, they ain't got a chance in hell of getting sober because of this and that. So less hope I think is one of the aspects and my view of the client and their progress of what they've done so far.*

Par-C:8:8

Participant G experienced doubt about services and the value of counselling for children, particularly when the counsellor heard their emotional trauma but was not able to fulfil the client's expectations that something would be done or changed. Additionally the organisation's initiative of providing support for children as a pilot scheme which was not maintained contributed to the counsellor's doubt. Finally the organisation which imposed a different level of confidentiality compared with the counsellor's normal practice increased the counsellor's sense of doubt.

*I ended up having quite a negative view of particular social services because my experience of it in that environment was pretty shocking and I think that had a knock-on impact in the other work that I do where I have communications with the social services, which kind of wasn't helpful to me anyway really, across the board.*

Par-G:5:18

*....trying to work with children on a basis to give them a good understanding, make them remember as you go through each session of what they say, you know, isn't always confidential, caused a lot of conflict for me and my way of working....I'm not sure counselling and therapy from that perspective is always that suitable, if the trust in the relationship seems kind of false.*

Par-:7:12

## **Counsellors experienced impact relating to attachment and detachment issues**

Detaching in various ways from clients, family and/or social groups were experienced by some counsellors. Participant C sensed a need to detach from the client and in personal relationships when he was at home.

*I hoped she gets sectioned and then I won't have to deal with it.*

Par-C:3:5

*I wanted a quiet space and not to be asked questions.*

Par-C:5:11

Participant B and F shared their sense of detaching from the client:

*I was finding it difficult to engage.*

Par- B:4:12

*I'm sitting there saying "well how do you feel about that, without actually engaging. I become non-engaged and that's not okay because it is through my engagement and through my energy that we bring in the patient's energy.*

Par-F:13:7

Participant G shared her experience of detaching when working with clients who present with lower level issues than clients who present with higher trauma level issues.

*Quite frustrating. And I think once I recognise the sense of frustration I find it really difficult to be quite as involved .... I definitely know I'm doing it, and I withdraw emotionally to a large degree, the compassion and the empathy that I felt for the other person isn't really there to a large degree.*

P-G:20:1

One participant explained that she had become emotionally detached from family and friends sharing two examples, one in response to a significant other's recent health check outcome and another in relation to a friend's medical health diagnosis. This explanation reinforced the participant's belief that her capacity for compassion is exhausted within her workplace.

*I wouldn't be so clinical and so empirical and detached from it. I'd be empathising and be more compassionate.*

P-D:6:9

*And I think they were quite hurt by it really, the fact that I didn't come forward and be helpful and caring and compassionate. I just completely distanced myself from it, to the point of not really asking how she was doing.*

P-D:8:10

## **Counsellors experienced satisfaction and sense of personal growth**

Interestingly counsellors experienced a sense of achievement and personal growth from the empathic understanding and compassion they shared with clients and the difficulties they faced as therapists.

*I'm quite philosophical you know, we learn, we stretch, we grow, don't we by our difficulties. It's a soft option to throw the towel in. That doesn't really help.*

Par-D:39:1

*I might have seen 5 or 6 people in a day and particularly one of the agencies that I work with where it can be really heavy going in the day, and there's always some sense of, even if I've got things to contemplate and my own emotions to kind of process when I come away, there's almost as though I get some sense of personal growth from that. It reinforces that actually, it's been worthwhile going there today and you know I might be tired, feeling a little bit drained sometimes but that's okay.*

Par-G-23:8

*So of course the whole thing is fascinating, this is one of the reasons why I do it but it is a strain.*

Par-E-31:20

## **4.2 What counsellors considered contribute to the cause of possible compassion fatigue**

In relation to what participants considered to be the causes of possible compassion fatigue, three themes emerged, although it is noted that for each participant themes appear to overlap or integrate.

### **Counsellors considered that personal factors may have contributed to their experience of possible compassion fatigue**

One participant shared how issues of personal performance anxiety led to bringing work home in order to meet organisational targets.

*I felt a great deal of pressure to perform and to be seen to be this amazing person.*

Par-B:3:7

*I'd gone by, really merging my work and my home life to a very unhealthy state.*

Par-B:7:7

Participant D shared her difficulty in having to change focus from personal trauma to workplace issues.

*....things at home have been very traumatic.... I think the compassion fatigue has been exacerbated by what's been going on at home.*

Par-D:37:13

Participant G was aware of personal issues being one of the causes.

*....when I had a lot going on at home....*

Par-G:1:15

### **Counsellors considered that issues in relation to the client contributed to their experience of possible compassion fatigue**

Participants observed the effects of working for specialist organisations, and consistently providing counselling for clients with similar issues. Participant B was



alerted to a possible cause which may have contributed to her experience of compassion fatigue when reading an article in a counselling journal.

*....you're hearing much the same over and over.*

Par-B:4:14

*I was bringing clients into my home who were grieving.*

Par-B-7:1

*I'd been working with grieving clients for ten years.... Nothing else, pure grief.*

Par-B:8:8

One participant considered that working for a specialist organisation and seeing clients with similar issues may hinder the counsellor's understanding and uniqueness of each client and therefore not always being aware of the impact on him as a counsellor.

*....because a lot of the client issues are quite similar to previous client we've had and can be quite the same, sometimes it's like working at Tesco's.*

Par-C:13:12

One participant, working for a hospice organisation, expressed her sense of not having any compassion left at the end of the day yet believing she had become less compassionate with clients. The counsellor considered issues that would probably be experienced by other therapists as horrific and/or traumatic had become routine work for her and perhaps detached from the trauma.

*....because it's part of my normal work I don't see it as anything separate and I am consciously aware that I am not, I could slip into not being as compassionate as I should be because it's not special, it's not different to me.*

Par-D:2:3

Participant E noticed a short-term impact when he first began hearing traumatic experiences described by clients and feeling relieved by the normalising of the supervisor.

*....it's very strange because it's got this combination which worried me when I first started hearing it, of being horrifying and you know sticking in your head, is horrible. ....I got worried when I first noticed that, when I was hearing it I'd only had about five or six clients when I heard them describe what happened to them, and I thought there was something strange about me, so I talked to my supervisor about it.*

*Part-E:35:1*

In addition to some personal causes, working with children at risk was considered to be a cause of compassion fatigue for Participant G. The counsellor developed an increased sense of responsibility and stronger attachment with child clients than adult clients, particularly when having no control over external organisations involved with the clients.

*I worked a couple of years back with children, for two years and I think that was my biggest experience really of compassion fatigue.*

*Part-G:1:18*

*There's something overly caring, over responsible. And I think some of that was born of kind of knowing that there weren't other people, quite often, other adults who were taking that personal responsibility for any given child that I was working with. And feeling somebody should.*

*Par-G:10:3*

There were challenges experienced regarding responsibility for creating the correct therapeutic intervention because of the possible consequences for the client. Also there being an absence of emotional connection with the client or knowing what the client needs created further challenge and level of responsibility.

*....if they don't get what they need to get out of it and then leave and start abusing and drinking then death is an option,*

*Par-C:28:5*

*....a greater responsibility....the stakes are so high, that's the problem.*

*Par-E:11:11*

*he was withdrawn, so it's very difficult to know with that particular client, do I leave the silence, for how long, do I make an assumption about what he wants to talk about because of what we'd talked about before, what is the most appropriate thing..... so many of the clients are withdrawn for many*

*months or year ....I'm working harder than I would do with the clients actually that make it clear what he or she wants.*

Par-E:14:3

*He said I'm relieved but there was no emotional signals of that at all, which is not uncommon with torture victims,*

Par-E:4:14

Not having a positive outcome with clients was also experienced as a difficulty by Participant D.

*There's no good end result apart from somebody having a peaceful death*

Par-D:11:11

### **Counsellors considered that issues in relation to the organisation contributed to their experience of possible compassion fatigue**

Participant C attributed his experience of stress to the organisation for a number of reasons including not having a sense of leadership and working in a residential setting.

*organisationally, sort of policies and procedures at times.  
That sort of infringed upon my practice in a way.*

Par-C:6:1

*Yes, quite intense, five days a week you know.*

Par-C:44:3

Performing a dual role within the organisation is explained by Participant E who acknowledged that providing practical support helps create a trusting relationship for later therapeutic work. Possible consequences for the client if failed by the organisation, helps rationalise the role conflict. The dual role for this participant, a person centred counsellor, also included advice, persuasion, having knowledge of cultures and working through an interpreter whom the counsellor may also have to counsel due to the traumatic material heard by the Interpreter.

*I have to do things that aren't counselling. So there is a sort of inner conflict going on,*

Par-E:7:23

*So there's a whole complexity and we have to find a way of guiding the client through it and guiding them when we can.*

Par-E:27:6

*I'm just giving you a few examples of why the work demands so much more time and brain power because there are all these other elements to it.*

Par-E:28:3

*There is a funny sort of conflict but never the less we are nearly all person centred counsellors so we have to find a way of doing it.*

Par-E:28:17

Having a dual role was reported as a positive experience for Participant F who integrates Hypnotherapy into her work with clients.

*I think with hypnotherapy you've got a way through compassion fatigue.*

Part-F:4:8

Having to write reports is an aspect of dual role that Participants E and G considered demanding and conflicts with conditions of therapeutic practice.

*....to provide very stringent reports.... the work demands so much more time and brain power because there are all these elements to it.*

Par-E:27:15

*....the other really difficult element of that work was having to compile any sort of report.*

Par-G:7:11

Working in a sense of isolation created stress and conflict for some participants engaged with organisations whose policies and practice do not appear to match the counsellors' ethical or moral standards. When clients are at risk and organisations do not communicate sufficiently counsellors felt more isolated, attached or

responsible to the client. Counsellors were subsequently left unaware of the client's outcome.

*....working in isolation but also that responsibility thing again..... I knew that it was the right thing for me to leave but it meant leaving a gap which I tried to fill and didn't succeed.*

Par-E:20:11

*....a couple of children I worked with where I would kind of take that home.....knowing that I wasn't at power to change..... while they collected enough evidence to actually remove them from the family home,*

Par-G:7:2

### 4.3 How Counsellors perceived supervision and support during their experience of possible compassion fatigue

#### Counsellors had positive perceptions of supervision during their experience of possible compassion fatigue

Participants valued supervisors being interested in the 'whole person' of the counsellor, including personal issues, well being and client work that may be supervised elsewhere. Participants also appreciated supportive challenge and enquiry of what is not said by the counsellor and the choice and expression of language. Having insight and sharing alternative perspectives was also valued, with two participants having a preference regarding opposite gender.

*We will start off with how I am personally, .....before we move on to my caseload.*

Par-D:18:12

*....she will always highlight if I've used the word just,*

Par-G:24:1

*....very good in picking up on a multitude of different things and tying things together, relating things that I can't see*

Par-G:27:7

*....a male because it's an opposing energy, if you will it is complimentary....*

Par-F:14:2

In addition to supervision peer support was valued by Participants C and D who are able to debrief with colleagues who are not necessarily counsellors and who provide alternative perspectives.

*....de-brief with colleagues really..... because it's a residential, everyone else sees where the clients are at as well. So you get another perspective in a way, which is quite useful.*

Par-C:18:3

*I've got a clinical director, who is a doctor, my line manager is our clinical services manager, and I can go and talk to them at any time about, if I've had a really bad session, well I've had an emotionally draining session I've got somebody I can go to and sit with and let it go, if I need to.*

Par-D:19:11

### **Counsellors had negative perception of supervision and support during their experience of possible compassion fatigue**

Negative aspects of supervision was shared by two participants, one of whom was able to be selective with what she presented to the supervisor and distract attention from her sense of trauma, fatigue and fear of being reported.

*....a selective list of topics so that I could very successfully hide the trauma that was going on within me because I felt that she would report me to the BACP.*

Par-B:32:14

One participant working in a hospice had valued supervision being external, structured and supportively challenging. However the supervisory relationship that had developed over a significant period of time changed when the supervisor sought support from the supervisee in relation to a recent personal medical diagnosis. This presented a professional dilemma for the therapist/supervisee.

*.... as a member of the human race, I should be caring about everybody... but the onus is on her to support me....*

Par-D:22:2

Participant G decided to discontinue attending a supervision group because she believed other members were not able to relate to her trauma based work.

*I'm not kind of convinced that the other people in that group regularly want to relate to that.*

Par-G:25:13

#### **4.4 How Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue**

##### **Counsellors had positive and negative views regarding initial counsellor training**

Participants considered that personal development is an important aspect of initial counsellor training curriculum. However participants had conflicting views as to whether personal development opportunities had been sufficiently provided. Participant B also believed that the training philosophy had been personally therapeutic, and influential in the decision to continue the professional path of counselling.

*There was a huge amount of personal development. We were meant to have 40 hours of therapy....And we had personal development groups .... set journal entries about how we were feeling and being brutally honest.... the tutors were exceptional .....they enabled me to start to look at who I really, truly was in a way that was supportive....that was hugely beneficial to my development as a counsellor.*

Par-B:37:9

*Twenty years ago no it wasn't sufficient, there wasn't the demand at that time for personal support.... I think it's kind of moved on and my institute's moved on it; demands all these things now, you have to have personal therapy as well. It was very rigorous training.*

Par-F:16:9

When reflecting upon preparation for specific counselling work two participants considered that there was insufficient training.

*I'm not sure the training was that apt for working with young people,*

Par-G:2815

*I think there is a big gap in training and our students have found that; they want and they've asked for more training in loss and grief, not so much bereavement, but loss and grief.*

Par-D:31:11



## **Counsellors had varied views regarding continuing professional development**

One participant had mixed views of the continuing professional development training provided by the organisation, valuing the regularity and its usefulness because it educates and informs about the traumatic history, complexities and legalities associated with survival of the clients he sees and their leave to remain in the country. Adversely the learning and use of this knowledge becomes demanding in time and brain power.

*...there is another aspect to the work with the torture victims which, I don't think is as emotionally affecting but it certainly takes a lot of my time and brain power....The organisation provides training for its counsellors and it's always on Saturdays, which I don't like my Saturdays being taken up but. .... I go to the training because it's useful.... we had a day of training on what we call transition..... the complexity of the whole system is incredible,.... I had another day of training on what we call medico-legal reports.*

Par-E:25:13

Counsellors had positive views of continuing professional development and valued being able to request and access training that meets their needs and interest.

*I cherry picked,....knowing I've got a CPD requirement is good, it keeps me out there looking.*

Par-F:17:1

Participants valued being able to access training that is specifically work related and training that is not specific to their current work. Having training needs documented was considered to support self worth and attribute responsibility appropriately.

*I'm well supported at work, any courses that I want to go on, if they're relevant to the work I do they're happy to fund them. And I like learning.*

Par-C:34:5

*....it's sort of noted somewhere in line management ...because if anything at a later date comes up or happens for whatever reason then they are more*

*accountable rather than myself,...I think that's important well really, valuing myself, not selling myself short really.*

Par-C:23:3

#### **4.5 How Counsellors perceived self-care in relation to their experience of possible compassion fatigue**

##### **Counsellors used forms of distraction as a method of self care**

Counsellors believed that forms of distraction are beneficial for their well being and therapeutic practice, using various methods including computer games, television programmes and physical exercise. One participant found spending some time chatting with staff a method of distracting and detaching from the work with individual clients.

*I spend quite a bit of time playing computer games, a bit of brain recovery time*

Par-C:12:8

*I like paragliding and I thinks it's got some sense of escapism,...I dance....I've got a routine going through my head and I switch off.*

Part-G:32:8

*I've got one particular computer card game that I'm obsessed with because I'm always trying to do better. But it switches me off, it's a distraction.*

Part-E:44:16

*....have 10 minutes of chatting with other people, and you know, you have, you've no kind of choice but to forget to some degree the depth of emotion you've just been working with, because you're thrown straight back into a different environment where everybody's chatting away and sociable. And that really helps me to switch off.*

Par-G:38:6

## **Counsellors created a sense of work/life balance as a method of self care**

Counsellors observed that creating a sense of work/life balance is beneficial to their well being and therapeutic practice. Initiatives include physical exercise, pleasure, social and therapeutic activities and taking regular breaks.

*I play golf,...I go out and walk the dog in the morning and the evening. I'm not doing much study at the moment so that's quite helpful.*

Par-C:12:4

*At the moment it's hill walking.... and there's gardening, there's DIY.*

Part-E:44:7

*....travel, that helps enormously or physical activity....very simple yoga exercises, ..... or some emotional freedom technique, that helps to wake me up.*

Part-F:2:3

*I think laughter is the best medicine. I mean if I really need to do something I will go to a stand up comedian, I will go to the theatre or go to something that really makes me laugh.*

Par-F:3:12

*...try to go for frivolous as a balance to the serious.*

Par-F:15:5

Time management strategies and boundaries were also observed by counsellors as being beneficial.

*....so I've now got a diary with like whole blocks of time...I have block of time that are just not for anything other than my sanity.*

Par-B:10:9

*I will see you at 12 o'clock rather than 3 o'clock on Friday. And so I prepared myself a bit more really.*

Part-C:3:12

*So we worked on boundaries stuff and I was able to do that quite well actually and it felt a relief, because somebody had given me permission to not be a workaholic if you like, and be constantly trying to prove myself.*

Part-B:7:8

## **Counsellors valued self awareness initiatives**

Counsellors believed that self awareness is an important aspect of their therapeutic work and personal well being, valuing personal therapy and development programmes.

*I think if I didn't have as much personal development stuff as I have done, I think I could have just carried on doing the same thing again and again quite easily.*

Part-C:30:11

*I suppose that insisting that you go for personal therapy as part of their training is going to help people realise that and get to a more stable place.*

Part-F:18:18

*I was aware that I was almost running the problems people were bringing to me, against my own problems.... I resorted, used a female psychodynamic counsellor to help me....in this personal aspect yes I'm very grateful for this counsellor's support.*

Part-F:14:11

#### **4.6 Issues which arose during Counsellors' reflection following the research interview regarding their experience of possible compassion fatigue**

Each participant took some time to reflect towards the end of the interview and shared what they considered either to be important with regard to preventing compassion fatigue or something new that had occurred whilst being interviewed and focusing upon the subject.

Participant B reflected upon being selective in supervision, discovering the benefit of being challenged by the supervisor.

*I am not a liar. If she asked me outright or challenged something about me I wouldn't be able to. So if I had been challenged I would have responded honestly to it.*

Part-B:35:5

Participant D reflected upon her new awareness of the physical effects of stress contributed by personal events. In relation to making any future changes the participant considered the concept of transference in the therapeutic relationship. This participant advocated pacing learning experiences.

*....you've pulled things out for me that I wasn't quite as aware of really, like my physical, the physical effects of the work that I do. Whilst I know that there are times when I can feel the physical stress even though I don't have a mental stress I need to be more tuned in to when my body starts changing, instead of just overriding it with more work.*

Part-D:36:1

*I think, I'm going to look out more for transference, be more aware of that really. I'm not sure about anything else at the moment.*

Part-D:36:16

*....starting at a gentle pace like our students are doing and then building to more complex cases and more complex people as you're training and your competences improve.*

Part-D:32:13

Participant E also valued the principle of gradual learning and the importance of self awareness.

*So I think my message is take it gradually. Don't suddenly jump into something that's really got a whole load of new challenges that you may or may not want to take.*

Part-E:42:8

*....the constant importance as a counsellor of knowing yourself and recognising you never completely know yourself but you need to keep working on it. Because you know if you are doing some counselling work that is challenging it's going to call up aspects of you that you need to be aware of.*

Par-E:43:5

Participant F considered the value in having awareness of energetic patterns.

*I think until we start to work with the energy of mental illness, and the energetic patterns that it throws out at other people, as well as what's going on inside, we are not going to be able to keep throwing people in there without expecting some kind of exhaustion.*

Part-F:26:4

Participant G believed in the benefit of multiple training placements that are team based.

*I think what would be nice to see is when people do their initial training to have to do more than 1 placement in a different environment.*

Part-G:34:10

*I think one piece of advice I would maybe give to people in training is if you can work in an environment where you are with a team of people, professions, that makes a world of difference.*

Part-G:36:1

Participants C, D and G reflected upon employment sickness benefits, financial implications, especially deciding to leave the type of work that contributes to fatigue and part-time employment. Participant G considered the question of accessing insurance policies to cover sickness leave.

*....what was difficult for me was dropping, the pay reduction, dropping hours at work. And I was trying to find something else part time.*

Part-G:36:8

*I've got my bulk of work that is paid, I would get sick pay, but I've got my other work that's more agency work, that I wouldn't get sick pay.....it certainly wasn't something that we ever touched on in training, that we were prepared for.*

Part-G:40:1

**Table 6. BREAKDOWN OF OUTCOMES**

| Category                       | Participant B | Participant C | Participant D | Participant E | Participant F | Participant G |
|--------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>IMPACT EXPERIENCED</b>      |               |               |               |               |               |               |
| Emotional Impact               |               |               |               |               |               |               |
| Behaviour Impact               |               |               |               |               |               |               |
| Cognitive Impact               |               |               |               |               |               |               |
| Somatic Impact                 |               |               |               |               |               |               |
| Sense of Doubt                 |               |               |               |               |               |               |
| Attachment/Detachment Impact   |               |               |               |               |               |               |
| Positive/Growth Impact         |               |               |               |               |               |               |
| <b>POSSIBLE CAUSE</b>          |               |               |               |               |               |               |
| Personal events/traits etc.    |               |               |               |               |               |               |
| Client                         |               |               |               |               |               |               |
| Organisation                   |               |               |               |               |               |               |
| <b>SUPERVISION AND SUPPORT</b> |               |               |               |               |               |               |
| Positive Comments              |               |               |               |               |               |               |
| Negative Comments              |               |               |               |               |               |               |
| <b>TRAINING AND CPD</b>        |               |               |               |               |               |               |
| Positive Comments              |               |               |               |               |               |               |
| Negative Comments              |               |               |               |               |               |               |
| <b>SELF-CARE</b>               |               |               |               |               |               |               |
| Methods of Distraction         |               |               |               |               |               |               |
| Methods of Balance             |               |               |               |               |               |               |
| Self Awareness Initiatives     |               |               |               |               |               |               |

*Please note the above table is not an attempt to diagnose, the purpose is to demonstrate comments made by participants*



## 5. DISCUSSION

This research study exploring the phenomenon of counsellors' experience of compassion fatigue ascertained six main categories. The first category relates to the impact of 'compassion fatigue' with counsellors experiencing behavioural, cognitive, emotional and somatic impact. Additionally counsellors experienced having a sense of doubt and issues related to attachment and detachment. The positive impact of satisfaction was also experienced by counsellors. Behavioural effects included crying; cognitive effects included irrational thoughts about the future and being out of control; emotional affects included irritation, anger, fear and, as Participant D shared, being "*drained of emotion*". Figley (1995) observes that arousal of emotion appears to be allied with people who have empathic and sympathetic reactions to others' trauma and in providing this care can become emotionally drained.

Somatic or physiological impact experienced by some participants included physical tiredness and exhaustion, which is acknowledged by Figley (1995, 2002b). One participant experienced having muscular disorder which Rothchschild (2000, 2006) refers to as somatic empathy communicated and expressed through the body. This may relate to therapist's empathic understanding of emotion stored in the body of clients who experienced childhood trauma (Dubovsky, 1997). Berger (2001) refers to somatic resonance, such as headaches, being related to projective identification or transference of the client's unspoken distress onto the therapist or to current stress or triggered wounds of the therapist.

Counsellors experiencing a sense of doubt included questioning or criticising themselves as therapists, client's ability to progress and of services. Berger (2001) identifies therapists' sense of dread which appeared to be experienced by one participant who "*hoped she gets sectioned and then I won't have to deal with it*", projecting much anger towards the client. This of course could also be interpreted as wanting to avoid or detach from the client.

Counsellors experienced feeling overly attached to some clients, sensing more responsibility and continuing to think about the client between sessions. Berger (2001) speaks of therapists holding on to clients' material excessively between sessions and how a merging or over-identifying with the client can be de-skilling for the counsellor. Counsellors also experienced wanting to detach or distance themselves from clients and their personal/social relationships. Disengagement is noted by Figley (2002a) as valuable in ameliorating compassion fatigue and Campbell (2007) reported that not being able to detach from a disaster increased vulnerability to stress.

The impact described by participants support Figley's (2002b) list of compassion fatigue stressors (Table 1, Appendix 2) and impact noted by McCann & Pearlman (1990) and others in Literature Review. Participant C described negative judgments and doubt of clients, suggesting the label of victim: "*they ain't got a chance in hell of getting sober*". With a focus upon counter-transference Danieli (1988) identifies themes of witness guilt, rage, shame, horror, grief, privileged voyeurism and includes casting the client as victim or hero.

Tiredness and exhaustion experienced by some participants may overlap or be identified as burnout (Maslach and Jackson, 1981). Physical exhaustion includes tiredness; emotional exhaustion includes hopelessness, and mental exhaustion includes resentment (Pines & Aronson, 1988).

In contrast, positive impact was experienced with counsellors gaining a sense of achievement/satisfaction from the empathic understanding and compassion communicated with clients. Participant G, a trauma therapist who described some of her work as “*heavy going*”, experienced a positive impact and shared her sense of personal growth: “*almost as though I get some sense of personal growth*”. Similarly I recall the ‘elation’ in the tone of voice as Participant E shared an experience of noticing the transformation in a client who was seeking asylum and emotional healing from torture: “*he’s bigger as a person*” and recalling how the counsellor had supported this process. This also supports Shakespear-Finch & Enders (2008) findings that PTG can be observed by significant others.

Steed & Downing (1998) report encouraging changes to therapist identity and belief about self and others and the phenomenon of posttraumatic growth in counselling psychology practice. Posttraumatic growth is highlighted by Sheikh (2008) and Tedeschi & Calhoun (1996) defining five main areas of posttraumatic growth. Their findings, and case study of Murphy (2009) is based upon Rogers (1951, 1957) grounded belief that humans are organisms inherently motivated towards growth and development and can actualise their potential within the right social environment. According to Bride, Radey & Figley (2007) not all therapists experience compassion fatigue noting the nourishing aspect of trauma work with Radey & Figley (2007)

observing that compassion stress can be used as a positive energy that culminates in compassion satisfaction.

The second category relates to what counsellors believe contributes to the cause of possible compassion fatigue within which three themes emerged: issues relating to the counsellor, the client and the organisation, with no apparent single cause being identified. All participants were generous in sharing issues such as personal traits, crisis and emotional, physical and practical demands. Examples of these include: *“having a lot going on at home, being a mother myself, working five days a week”*. One participant who also experienced work related stressful events acknowledged a sense of duty: *“it’s that responsibility thing again”*. Another participant was affected by a *“major trauma in the family”* and at a similar time was allocating students the lighter work. This prevented a balanced case load, which is associated with Secondary Traumatic Stress and Compassion Fatigue (Boscarino, Figley & Adams 2004; Creamer & Liddle 2005; Meyers & Cornille 2002).

Figley (1995) suggests that counsellors who have no realism in their performance and find themselves overworking with high ideals and overinvestment in meeting all clients’ needs are vulnerable to compassion fatigue. Sedgwick (1994) advises that a life crisis for the therapist may limit the therapist’s emotional resources and demand difficult yet sometimes fortuitous differentiations. Participant B who experienced personal loss became enmeshed in bereavement therapy and having a personality trait of *“trying to be this amazing person”* appeared to overinvest in meeting client’s needs, brought work home, resulting in a depletion of work/life balance. Interestingly Integrating Buddhist psychology of acceptance and mindfulness provides an

opportunity for spiritual growth and transformation helping grief counsellors cope with the emotional toll that can lead to burnout or compassion fatigue (Wada & Park, 2009).

Schmid (2001a) describes true empathy as a relational variable that requires the therapist to play an authentic part in the therapeutic relationship and in so doing comes with a risk. Wilson & Thomas (2002) also warn of empathic strains that disrupt the therapist's ability to sustain empathic inquiry and maintain empathic accuracy in decoding signal transmission from the client. Participant D referred to being "*exhausted by the compassion*", and being "*too exhausted to show it*".

Repetitive exposure to trauma material was experienced, particularly by two participants working with bereaved and dying clients. Sprang, Clark & Whitt-Woosley (2007) note the wisdom in developing an optimal 'caseload mix,' for the prevention of compassion fatigue and burnout. Stamm (1999a, 1999b) proposes that death is a stressful life experience that can result in traumatic stress responses that may lead to traumatic stress disorder, or pathological grief and the importance for therapists to distinguish between the closely linked normal grief response and traumatic stress response. For this reason it is understandable why participants working solely in the field of bereavement and dying experienced fatigue. Berzoff & Kita (2010) however note the enormous satisfaction derived from being present in one of life's most mysterious moments when entering the space of a dying client.

Participant E experienced professional uncertainty when working with clients traumatised by torture, who were withdrawn, silent and described as having such a

lost sense of self it was like observing “*death without being killed*”. This experience supports findings of Deighton, Gurriss & Traue (2007) who report frustration in therapists who achieve a low level of working through client's trauma and believe that witnessing client behaviour in session and knowing of traumatic history may cause secondary trauma and insecurity. Burchell (BACP, 2008) notes the complexities of working with asylum seekers and refugees and warns of the risk of compassion fatigue and the need for therapist self-care and appropriate supervision. Dutton & Rubinstein (1995) and McCann & Pearlman, (1990) noted that therapists working with clients who remained at risk of human-induced trauma reported more symptoms related to compassion fatigue. These studies affirm the experience of three participants knowing that their clients remained “*at risk*” had the challenge of working simultaneously with the aftermath and possible future traumatic events. Blackwell (2007) notes threat of deportation can hang over the therapeutic context provoking a sense of impotence and hopelessness for the therapist. Figley (1995) also notes that prolonged exposure to compassion stress means having a continuous sense of responsibility for the care of the client. This can reduce the therapist's opportunity to reach a sense of achievement in lessening the suffering of the client. Not having a sense of achievement was experienced by some participants which according to Figley (1995) would prevent therapists attaining the positive impact of compassion satisfaction

Organisations that bring complexities and duality to the role, was experienced by some counsellors, particularly by one participant who struggled with the conflict of not always counselling and the strain of switching from one role to another. Meldrum, King & Spooner (2002) recognise that role complexity and ambiguity are

significant work stressors and may be linked with STS symptoms. Dual roles included counsellor/manager, counsellor/clinician, counsellor/adviser, counsellor/administrator with tasks of writing reports being of particular note for some participants. One trauma counsellor working with: cultural difference, communicating through interpreters, liaising with legal personnel, and having knowledge of process for asylum seekers such as 'leave to remain' and advising, are examples of complexities. Complexities and tailored therapy when working with torture survivors are noted by Blackwell (2007) and Burchel (BACP, 2008) that may have significant psychological impact upon the therapist. Lansen (2001) notes that therapists working in treatment centres for torture victims are expected to complete extraordinary tasks and that highly motivated staff can easily become burdened and exhausted. Working with interpreters, for whom one participant often provided debriefing or therapy, is noted by Trivasse (BACP, 2010) as having considerable complexities and repercussions in terms of interpreting word meaning (Blackwell 2007). Birck (2002) reports compassion fatigue being low for interpreters and administrative employees and extremely high for therapists, believing that having to write health certificates in support of reducing the risk of deportation for the client, poses significant risk factors for secondary traumatising. For Participant F the additional provision of hypnosis produced a positive dual role experience, enhancing therapeutic process and self-care strategy, which reflects Ruyschaert's (2009) claim that self-hypnosis promotes compassion satisfaction, resilience and guards against compassion fatigue.

Stress relating to conflict of moral and ethical boundaries was experienced by two participants who sensed isolation, increased responsibility and difficulty with one

participant when the organisation lacked structure. The context in which the counselling takes place is seen to be a contributory cause of impact related to the spectrum of compassion fatigue and secondary trauma (Etherington 2009, Stewart 2004). Obholzer & Roberts (1994) observe the impact of organisational chaos, change and uncertainty, nature of service, such as the dying and damaged children, and organisational tensions which need to be managed.

Regarding supervision and support most participants shared their sense of satisfaction, welcoming structure, being supportively challenged and the supervisor being interested in the whole person of the counsellor. Supportive challenge is recognised as a valuable supervision intervention (Page & Wosket, 1994). The ability to be congruent in supervision was valued, evidenced by one participant who shared how his supervisor and colleagues would know when he was stressed by change in his language. Two participants favoured opposite gender, with one participant commenting favourably on having supervisors from the same counselling theoretical modality. Another participant experienced supervision being split between clinical and organisational which reflects the dual role referred to previously in this study. Additional consultation was valued by two participants who were able to debrief and receive support when necessary with colleagues, including the line manager which reinforces findings of Barlow & Phelan (2007) that peer collaboration is beneficial on many counts including counsellor self-worth.

One participant did not have a positive experience regarding group supervision in terms of presenting work related to childhood sexual abuse. The same counsellor appeared unsupported by the organisation whilst working with children at risk. This



appears contrary to the belief of Trippany, White Kress & Wilcoxon (2004) who observe value in peer supervision, noting the responsibility of supervisors to provide a VT-preventative environment. Meyers & Cornille (2002) advise that having a supportive environment including peer support groups where therapists have a safe place to release emotions and talk about specific trauma, fears and regrets helps minimise the adverse effects of working with child abuse victims. External supervision was valued for different reasons by several participants although there were no negative comments regarding internal supervision.

One participant, able to be selective in what she brought to supervision fearing that her fatigue would be recognised and reported, shared that she would have preferred to be challenged by her supervisor. Etherington (2000, 2009) notes, that being overwhelmed may be deemed shameful by counsellors who pride themselves in being resilient. Another participant shared that her supervisor noticed clients not presented, reinforcing Etherington's (2000, 2009) observation that supervisors may realise when some clients are never brought to supervision, particularly when time is taken up by the therapist with too much material. Webb (2000) also notes that supervisees have a tendency to present selectively, excluding some clients completely for reasons including fear of consequences. According to Pearlman & Saakvitne (1995) regular supervision is essential for therapists' self-care and ethical commitment to their clients. They believe that supervision must afford a place for therapists to discuss cases and their responses to the work without shame. Webb & Wheeler (1998) report that counsellors are less likely to disclose sensitivities when engaged in other than individual supervision, when the supervisor is not chosen by the counsellor and when supervision is provided by the same organisation setting as

the counselling, with trainee counsellors being similarly inhibited (Webb & Wheeler 1998; Mehr, Ladany & Caskie 2010). The supervisory alliance also bares a reflection upon non-disclosure which may be caused by: the supervisor's approach not meeting the supervisee's needs or, the supervisee seeking perfectionism and approval fears judgment from the supervisor (Arkowitz 1990). Supervisors may use their power to influence decisions regarding whether therapists continue to work whilst experiencing personal anguish. However King & Wheeler (1999) discovered that supervisors were reluctant to advise supervisees to take time out when faced with personal distress. Wheeler (2007) believes that vulnerability should not be viewed as failure and when collaboratively acknowledged, provides understanding that supports reflective, transitional learning. Reflective practice is also promoted by Carroll (1997) to help supervisees gain greater understanding of themselves and their practice. Shohet & Wilmot (1991) acknowledge the place of anxiety in the supervisory relationship and warn against smoke screens used by either party to hide their fear, just as counsellors may hide their anxiety through their client, supervisors may hide their anxiety through supervisee.

Group supervision was viewed unfavourably by one participant who believed the members did not wish to discuss her work with adult clients who suffered childhood abuse. According to Page & Wosket (1994) counsellors need supervision that holds and tolerates the trauma of the client's story including secondary trauma, providing a sanctuary for the counsellor and indirectly the client, preventing deflection and collusion of the client's *modus operandi*. For therapists working with adult survivors of childhood sexual abuse Walker (2004) notes the required attributes of the supervisor should include an awareness of secondary traumatised and symptoms

of post traumatic stress disorder. Page & Wosket (1994) advise counter-transference and unconscious processes should be considered as group dynamics may disable effectiveness, possibly resulting in one member feeling abused and driven out. However Alonso & Rutan (1988) believe that the supervision group is best suited for helping supervisees with low self-esteem and Ethington (2000, 2011) promotes the value of group supervision in preventing isolation for therapists working with sexual abuse trauma, recognising that as clients need support so do counsellors.

A change in the supervisory relationship was brought about by unforeseen circumstances, creating some concern for Participant D in terms of being supported by the supervisor and able to talk freely. As discussed previously in this study the working alliance contributes to how open the supervisee can be and it is noted that the supervisor has a professional and ethical obligation to engage in supervision of supervision, appropriate support and take personal consultation when necessary (Page & Wosket 1994).

Participants reported negative and positive experiences of initial training and continuing professional development with comments regarding initial training having a lack of focus on specific areas of work, such as bereavement, trauma and children. This reflects findings of Gubi & Jacobs (2009) and Stewart (2004) regarding absence and inadequate training in preparation for specific work demand and complex organisational context. According to Adams & Riggs (2008) and Salston & Figley (2003) students require substantial trauma specific training in the context of coursework or intensive workshops rather than single lecture or discussion.

Students need to gain knowledge about the intensity of trauma work, its impact and recovery for both client and therapist (O'Halloran & O'Halloran 2001). Interestingly some participants noted valuable inclusion of personal development and consultation in their initial training. However there was no mention of counselling curriculum including the possible impact of counselling upon the therapist which reflects Gubi & Jabobs' (2009) findings. One participant considered theoretical training that is too rigorous may lose the natural intuition, wisdom and knowledge of the trainee and that personal therapy if legislated may also lose its function. This may have been evidenced by one participant whose therapy during training did not appear to have prevented their experience of compassion fatigue. Interestingly the same participant learned of the phenomenon and self diagnosed when reading and attending a therapy conference as part of her ongoing professional development. Skills and knowledge gained from previous professions when trust was crucial, exposure to different cultures and ongoing training enabled Participant E to confidently conduct the role of therapist.

Counsellors' perception of self-care included themes of distraction, work/life balance and self-awareness which correlate with Saakvitne & Pearlman's (1996) assessment and intervention strategies for vicarious traumatisation. In terms of distraction it is interesting that the two male participants engaged in computer games as a means of distraction and a variety walking exercises to achieve life balance. One participant engaged in dance and paragliding, describing them as activities that require concentration which enabled distraction. To implement balance counsellors took up travel, physical exercise, yoga, meditation, absorbing personal environment of the home, faith, fun and socialising which is also identified by Saakvitne & Pearlman

(1996) and Alkema, Linton & Davies' (2008) who reported that compassion satisfaction significantly correlated with emotional, spiritual and personal and professional balance. Balance was also achieved by implementing boundaries such as time management, variety of case-load, and diary management. Self-awareness was achieved through reflection and personal therapy. Personal therapy is perceived favourably by experienced therapists for personal growth, self-care and management of personal distress (Daw & Joseph, 2007) and ethical practice (Carroll, Gilroy & Murra, 2003).

Acknowledgement of empathy fatigue and the importance of therapist self-awareness, lifestyle balance and social/peer support is noted by O'Halloran & Linton (2000), Stebnicki (2007) and Weiss (2004) to maintain self-care which Evans & Pyne (2008) identify as promotion for individual well-being and professional retention. Engaging in pleasure activities, exercise, hobbies, socialising, support, knowledge, sleep and diet are recommended strategies for well-being, some of which can be measured against a 'Coping Strategies Inventory' (Bober, Regehr & Zhou 2006). In terms of balance and pleasure, Participant F found the activity of laughter to be the right "*medicine*" which endorses Weiss (2004) and Yassen's (1999) value of humour. Mindfulness practice increases self-awareness and responsibility for implementing self-care strategies (Greason & Cashwell 2009; Richards, Campenni & Muse-Burke 2010, Christopher & Maris 2010, Schure, Christopher & Christopher 2008). Although not discussed by participants Patsiopoulos & Buchanan (2011) note self-compassion is associated with self-care and prevention of burnout.

None of the participants appeared to use any structured form of self-assessment such as Impact of Event Scale-Revised [IES-R] (Weiss & Marmar, 1997, 2004). Also participants did not refer to any of the formal recovery programmes such as the Accelerated Recovery Programme [ARP] (Gentry, Baranowsky & Dunning (2002) but did informally acknowledge elements of the recovery and resiliency programmes

Finally when participants reflected upon the interview regarding their experience of possible compassion fatigue comments were shared relating to the following issues:

1. Needing to be supportively challenged in supervision
2. New awareness of the physical impact of stress and needing to be more attuned to body
3. Importance of gradual learning opportunities, appropriate training placements and supportive teams
4. Importance of self awareness
5. Importance of monitoring energetic patterns to prevent exhaustion
6. Organisational responsibility for staff welfare, employment conditions and financial security

With the exception of item 6 all items have been addressed by authors within the literature review reflecting participants' experiences. With regard to staff welfare, including employment and financial security, there appeared to be little literature or research on the subject.

Countertransference was briefly referred to by two clients, one of whom advised that although having never previously considered the concept had become interested in learning more as a result of the interview process.

## **6. CONCLUSION**

There appears to be much overlap, ambiguity (Coetzee & Klopper, 2010) and critique (Berzoff & Kita, 2010) between the terms and components related to compassion fatigue. However for some of those who care for others fatigue and stress undoubtedly exist in varying degrees and nature, evidenced by the literature review, research findings of this study and validation studies such as Jenkins & Baird (2002).

This research study identified the following 6 outcome categories in relation to counsellors' experience of possible compassion fatigue, all of which correlate with the literature review:

1. Counsellors experienced behavioural, cognitive, emotional and somatic impact of possible compassion fatigue and impact relating to issues of doubt, attachment and detachment
2. Counsellors identified a variety and combination of perceived causes that may have contributed to their experience of possible compassion fatigue
3. Counsellors perceived supervision and support during their experience of possible compassion fatigue as being both negative and positive experiences
4. Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue as being both negative and positive experiences
5. Counsellors perceived self care initiatives such as methods of distraction, work/life balance and self-awareness as being important for the prevention and amelioration of compassion fatigue
6. Issues which arose during counsellors' reflection following the research interview regarding their experience of possible compassion fatigue included the importance of organisational responsibility for staff welfare, working conditions and financial security



There were two outcomes of this study which had not been anticipated, namely resilience and growth. Resilience is a characteristic of trauma therapists recognised by Hernandez (2010), Hernandez, Gangsel & Engstrom (2007) and Wicks (2008) that I observed in the therapists interviewed and by therapists within my network. I was moved by the words of one participant:

*But that's where my faith kicks in really. Because I believe that what's happening is part of a much bigger picture and that what I have to do now won't last forever and it's a case of this is almost the task that I've got to do within the family.*

Par-D:27:14

*I'm quite philosophical you know, we learn, we stretch, we grow, don't we by our difficulties. It's a soft option to throw the towel in. That doesn't really help.*

Par-D:39:1

Resilience and growth are possible topics for future studies in terms of what creates resilience and personal growth for therapists. Self-care initiatives, supervision and impact of employment security could also be related topics for future studies.

I consider it important to pay attention to the risks of compassion fatigue, its causes, prevention amelioration and recovery. Adams, Boscarino & Figley (2008) claim that detection of compassion fatigue is a prelude to creating strategies that will alleviate its negative impact on caregivers. Figley (2002a) claims that professionals have a responsibility to raise greater awareness of compassion fatigue, its detection and alleviation of negative impact to prevent loss of clients and compassionate psychotherapists. Although this small scale study is limited by its findings, it does leave opportunity for further research and to continue the campaign for therapists' well being.

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## APPENDIX 1. EPILOGUE

### Research origin

The subject of this qualitative research originates from a heuristic perspective. As a newly qualified counsellor I worked in an agency that offers counselling to adult survivors of childhood sexual abuse and was seeing ten clients per week which represented fifty per cent of my counselling workload. Adult clients who have been abused as children may present themselves to the therapist with symptoms of long-term effects of childhood trauma (Finkelhor, 1986), including psychological distress and post-traumatic affects (Sanderson, 2006). During this early experience I remember myself becoming rather clinical, overprotective of family, concerned for the safety of children generally and developed a vivid imagination. When socialising I was silently cynical of adult's conversation regarding general complaints about their life whilst I was thinking that they had no idea or seemed to have no concern with what other people have experienced and coped with. Confidentiality naturally did not permit me to enlighten people with whom I socially interacted, which resulted in me feeling rather isolated. I found that my response to humour of a sexual nature became distant and experienced a negative effect to my libido.

I believe that my experience could be symptoms of what Figley (1995) describes as compassion fatigue or secondary traumatic stress (STS) and what McCann and Pearlman (1990) describe as vicarious trauma. I now have ten years post qualified working experience as a counsellor and currently work for the National

Health Service as a primary care counsellor and hear disclosure of traumatic experiences that vary in level of emotional, physical, cognitive and somatic impacts and which draw upon my deep empathic engagement with the client.

I do not experience such shock as I did in the early stages of my counselling career but there are times, when my energy levels deplete, have occasional patterns of disturbed sleep, perhaps a sense of frustration and sorrow, all of which I am able to safely express and reflect upon during supervision and personal consultation. I become aware of needing to redress the balance and increase the fun and pleasure element of my personal life. Primary care venues are not all conducive to counselling and political pressures and expectations can be challenging. I have observed some colleagues needing to take time from work to regenerate energy. Taking personal experience, observation of colleagues and limited review of related literature into consideration I was compelled to learn more about counsellors' experience of compassion fatigue and promote work life balance and well being for counsellors.

### **Reflection of the research study**

Figley's pioneering work in recognition of combat stress and battle fatigue led to the discovery of the concept of compassion fatigue. He observed these traumatised war veterans return to their families who through their emotional empathy with their loved ones became lost in trauma themselves. I find myself intrigued that we may have reached a 'full circle' in this phenomenon.

Although participants in this study did not make specific reference to clients suffering from combat stress or work loss, I believe these are current major causes for traumatic response. I was particularly drawn to the research of Tyson (2007), probably because of the prominent armed forces within my living area and being emotionally moved by the work of the Ministry of Defence [MOD] and Cruse Bereavement Care (2009) in supporting military families in their bereavement of war veterans, particularly loss of sons and daughters. Stamm (1999) notes the normality of stress in response to death which may have a traumatic stress response depending upon the situation. Death from extreme events such as disaster, war, starvation or genocide is a potential risk factor for traumatic stress responses (Stamm, 1999). We hear (or don't hear) of young injured combat veterans having to return perhaps to civilian life in a current climate of unemployment, reduced services and financial stress.

With the current financial climate I also perceive there are likely to be young clients suffering from the trauma of not having a future in terms of their professional and personal development and resorting to adverse coping strategies such as substance abuse and self-harm and suffer from chronic physical health which in turn brings more clients to our consulting rooms. Due to the current financial strain these clients are turning to consulting rooms that have either reduced services, particularly in the counselling field with the prominence of "Improving Access to Psychological Therapies" (IAPT) and Cognitive Behaviour Therapy (CBT), or to counsellors who they themselves are feeling threatened by job cuts.

Similarly therefore applying the principle of posttraumatic growth for the therapist, variants may vary depending upon the case load in terms of level of trauma experienced by the client and complexities of impact, depth of therapeutic relationship, longevity of therapeutic relationship, number of trauma clients seen and the therapist's personal stress coping mechanisms. I believe that compassion satisfaction plays a significant role for growth and therapists benefit from understanding the level of their need for satisfaction, their psychological traits and for taking responsibility of all aspects of their self care. However I do believe that organisations have a responsibility and duty of care to their employees. Provision of sufficient supportive initiatives should be provided not just to prevent compassion fatigue but to nurture the growth possibilities which inevitably will benefit clients and the organisation. I encourage further research regarding this phenomenon. It would be interesting to view some realistic evaluation tools for therapists to complete regarding satisfaction with their employment terms and conditions.

I believe that therapist's psychological traits play a part in therapy and I do believe that these traits contribute to the reasons why counsellors chose the profession and have a responsibility to be self aware, professionally responsible and personally responsible for their self care. However organisations that employ or contract counsellors also have a responsibility for the wellbeing of the employee and to provide employment conditions that include appropriate training, support and wellbeing initiatives as opposed to taking advantage of the 'willing horse.'

Reflecting upon the process of undergoing this research study I have personally gained knowledge and insight to the phenomenon and had the opportunity to reflect

upon my professional practice and personal self care. In bringing therapists attention to the subject of compassion fatigue by the advertisement alone has invited therapists to consider the phenomenon even for those who expressed an interest and decided not to participate for whatever reason. For those therapists who participated in the study I believe that I provided an arena offering an opportunity to focus upon the phenomenon, particularly by the interview process. Participants were able to bring their experiences into awareness, reflect, perhaps reassess and acknowledge what is more suited to their well being as practitioners and observe changes they may have already made and any they wish to consider. Some participants provided feedback regarding the interview being a cathartic experience and my summarising being useful. I received communication enquiring about the progress of the study and to be given additional information. This gives me the satisfaction of knowing that the study has been worthwhile.

In conducting this research study my hope was for my awareness, knowledge and professional skill in relation to compassion fatigue to increase. As a result I hoped to prevent the risk of compassion fatigue and ultimately provide greater quality of therapy for my clients. Since conducting the study I have become more focused upon self-care issues and have become 'mindful' in my philosophy and approach to my professional and personal encounters.

I have discovered sufficient evidence to suggest that negative and positive impacts exist within the work of the counselling community. It is my belief that counsellors, organisations and educational institutions perhaps need to be responsible in raising



awareness of this phenomenon and take a greater responsibility in promoting self care and well-being initiatives.

Just recently I visited a hospice and was overjoyed to observe some of its care staff, including counsellors, just about to begin a meditation session! My confidence was restored that organisations are able to provide an arena for such beneficial activities for the welfare of staff and clients and staff are committed to engaging in well being initiatives.

**APPENDIX 2. Table 1. Examples of Compassion Fatigue Burnout Symptoms (Figley, 2002b, page 7).  
(Referred to on pages 7 and 63 of main dissertation document)**

| <b>Cognitive</b>  | <b>Emotional</b>   | <b>Behavioural</b>   | <b>Spiritual</b>  | <b>Personal Relations</b>  | <b>Somatic</b>  | <b>Work Performance</b>  |
|---|--|--|---|--|---|--|
| Lowered concentration<br>Decreased self-esteem<br>Apathy<br>Rigidity<br>Disorientation<br>Perfectionism<br>Minimization<br>Preoccupation with trauma<br>Thoughts of self-harm or harm to others | Powerlessness<br>Anxiety<br>Guilt<br>Anger / rage<br>Survivor guilt<br>Shutdown<br>Numbness<br>Fear<br>Helplessness<br>Sadness<br>Depression<br>Emotional roller coaster<br>Depleted<br>Overly sensitive | Impatient<br>Irritable<br>Withdrawn<br>Moody<br>Regression<br>Sleep disturbance<br>Nightmares<br>Appetite changes<br>Hyper vigilance<br>Elevated startle response<br>Accident proneness<br>Losing things | Questioning the meaning of life<br>Loss of purpose<br>Lack of self-satisfaction<br>Pervasive hopelessness<br>Anger at God<br>Questioning of prior religious beliefs<br>Loss of faith in a higher power<br>Greater scepticism about religion | Withdrawal<br>Decreased interest in intimacy or sex<br>Mistrust<br>Isolation from others<br>Overprotection as a parent<br>Projection of anger or blame<br>Intolerance<br>Loneliness<br>Increased interpersonal conflicts | Shock<br>Sweating<br>Rapid heartbeat<br>Breathing difficulties<br>Ache and pains<br>Dizziness<br>Increased number and intensity of medical maladies<br>Other somatic complaints<br>Impaired immune system | Low morale<br>Low motivation<br>Avoiding tasks<br>Obsession about details<br>Apathy<br>Negativity<br>Lack of appreciation<br>Detachment<br>Poor work commitments<br>Staff conflicts<br>Absenteeism<br>Exhaustion<br>Irritability<br>Withdrawal from colleagues |

**APPENDIX 3. Table 2. Psychological Distress and Dysfunction (Dutton & Rubinstein, 1995, page 85).  
(Referred to on pages 7 of main dissertation document)**

| <b>Psychological distress or dysfunction</b>                                   | <b>Manifest as:</b>   | <b>Authors</b>   |
|--|---|--|
| Distressing emotions   | Anxiety, dread, rage, shame   | Courtois, 1998; McCann & Pearlman, 1990; Scurfield, 1985             |
| Intrusive imagery  | Nightmares and flashbacks of client's trauma  | Courtois, 1998; Herman, 1992a; McCann & Pearlman, 1990               |
| Numbing or avoidance to elicit or work with traumatic material from the client |   | Courtois, 1998, Herman, 1992b; McCann & Pearlman, 1990; Silver, 1986 |
| Somatic complaints   | Sleeplessness, headaches, gastrointestinal distress and heart palpitations  | Figley, 1986; Herman, 1992b  |
| Addictive or compulsive behaviours   | Substance abuse, workaholism and compulsive eating.   | Boylin & Briggie, 1987   |
| Physiological arousal  |   | McCann & Pearlman, 1990; Van der Kolk, 1987                          |
| Impairment of daily functioning  | Missed appointment, decreased use of supervision or co therapy, lateness, none engagement in self care, feeling isolated, alienated and unappreciated | Boylin & Briggie, 1987   |

## **APPENDIX 4. Table 3. Vicarious Traumatization Intervention Strategies for Each Realm of the Helper's Life (Saakvitne & Pearlman, 1996)**

*(Referred to on pages 15 and 73 of main dissertation document)*

### **Professional**

- Supervision/consultation
- Scheduling: client load and distribution
- Balance and variety of tasks
- Education: giving and receiving
- Work space

### **Organisational**

- Collegial support
- Forums to address VT
- Supervision availability
- Respect for clinicians and clients
- Resources: mental health benefits, space, time

### **Personal**

- Making personal life a priority
- Personal psychotherapy
- Leisure activities: physical, creative, spontaneous, relaxation
- Spiritual well-being
- Nurture all aspects of yourself: emotional, physical, spiritual, interpersonal, creative, artistic
- Attention to health

### **In All Realms**

- Mindfulness and self-awareness
- Self-nurturance
- Balance: work, play, rest
- Meaning and connection

## APPENDIX 5. SEARCH STRATEGY - DATABASES AND SEARCH TERMS

### Search Strategy

The search strategy used for this research study was by referring to literature published in journals and books on compassion fatigue and related subjects. Research articles were accessed electronically via databases using the following electronic databases and search terms:

#### **Databases:**

- Education Research Complete
- Psyc-INFO
- PsycARTICLES
- PsycBOOKS
- Psychology and Behavioural Sciences Collection
- SocINDEX with full text

#### Search terms:

- Compassion fatigue
- Secondary traumatic stress
- Vicarious trauma
- Burnout
- Couns\* and compassion fatigue
- Couns\* and stress
- Psychotherapy and compassion fatigue
- Psychotherapy and vicarious trauma
- Countertransference and vicarious trauma
- Countertransference and burnout
- Post-traumatic growth
- Post-traumatic growth and psychotherapy
- Post-traumatic growth and counselling
- Compassion satisfaction
- Coun\* supervision

**Search terms continued:**

- Psychotherapy and burnout
- Countertransference and compassion fatigue
- Coun\* self-care
- Psychotherapy supervision
- Psychotherapy self-care
- Resilience

## Invitation for Experienced Counsellors to Participate in a Research Project

**TITLE: A Qualitative Study of Counsellors'  
Experience of Compassion Fatigue**

***'The very act of being compassionate and empathic  
extracts a cost under most circumstances.'***  
***(Figley, 2002)***

I am a counsellor currently undertaking a research project as part of Masters Degree in Counselling Studies at the University of Chester. I am interested in and wish to promote the wellbeing of counsellors and welcome the opportunity of hearing counsellors' experience and awareness of Compassion Fatigue.

One to one interviews will be arranged, following the completion of a brief questionnaire, and conducted with the strictest of confidentiality and anonymity.

If you are a practising counsellor with a minimum of 4 years experience, willing to discuss your awareness and experience of Compassion Fatigue and would like more details without obligation please contact:

Marilyn Lowther  
[marilyn.lowther@btinternet.com](mailto:marilyn.lowther@btinternet.com)



## APPENDIX 7. JOURNAL ADVERTISEMENT

*M.A Counselling Student is seeking counselors with a minimum of 4 years experience to participate in a research study and willing to discuss their awareness and personal experience of compassion fatigue.*

*Face to face interviews arranged – respecting confidentiality and anonymity*

*Interested participants please contact:*

*Marilyn Lowther*

*[marilyn.lowther@btinternet.com](mailto:marilyn.lowther@btinternet.com)*

*Participants wanted for University of Chester Masters research. If you are a counsellor willing to discuss your awareness and experience of compassion fatigue please e-mail [marilyn.lowther@btinternet.com](mailto:marilyn.lowther@btinternet.com)*



## APPENDIX 8. LETTER REQUESTING ADVERTISEMENT TO BE DISPLAYED

[marilyn.lowther@btinternet.com](mailto:marilyn.lowther@btinternet.com)

8 March 2010

*Address Here*

Dear Colleague

### **Re Masters Degree Research Study**

I am a counsellor working for the NHS in GP surgeries and currently studying for a Masters Degree in Counselling at the University of Chester. I am writing to request that you display the enclosed poster inviting counsellors to participate in my research study entitled '*A qualitative study of counsellors' experience of compassion fatigue.*'

Formal ethical approval has been granted for this study by University of Chester Ethics Committee.

If you have any further queries about the study please do not hesitate to contact me.

Thank you for your kind assistance.

Yours sincerely

Marilyn Lowther

Enc

## APPENDIX 9. LETTER TO RESPONDENTS

[marilyn.lowther@btinternet.com](mailto:marilyn.lowther@btinternet.com)

*Date*

*Address*

Dear Participant (*put name here*)

**Re: Masters Degree Research Study**

Thank you for expressing your interest to participate in this research study entitled '*Counsellors' Experience of Compassion Fatigue*,' which is part of a Masters Degree in Counselling Studies at the University of Chester.

Before you decide whether you would like to participate, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the information sheet carefully.

If you agree to participate in the study please complete and return the enclosed *Initial Questionnaire* and *Informed Consent* documents. The Questionnaire will help me select a maximum of six counsellors from a range of backgrounds and counselling environments to take part in a one to one interview. A summary of data from the completed Questionnaires may be included in the final dissertation.

If you are selected to participate in a one to one interview I will contact you to arrange a suitable date, time and venue. You may withdraw from the research study at any time without obligation.

If you have any further queries about the study or any of the documents please do not hesitate to contact me.

Thank you for your kind assistance.

Yours sincerely

Marilyn Lowther

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**UNIVERSITY OF CHESTER**  
**DEPARTMENT OF SOCIAL AND COMMUNICATION STUDIES**  
**Masters Degree in Counselling Studies**  
**Research Study - Information Leaflet**

**Research Study Title:**     ***Counsellors' Experience of Compassion Fatigue***

Before you decide whether you would like to participate in this research study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the information sheet carefully.

**The Researcher**

I am Marilyn Lowther currently studying at the University of Chester for a Masters Degree in Counselling Studies. I am a qualified counsellor.

**What am I researching?**

I am carrying out a research study to explore counsellors' experience and awareness of compassion fatigue within their work. I aim to do this by asking interested counsellors to firstly complete a questionnaire and secondly to participate in an individual discussion at a time and venue to suite the individual. I will be using a qualitative research method.

**Who will be invited?**

I am seeking counsellors who have a minimum of four years experience working in a range of environments such as private practice, National Health Service, agency and education. Participating counsellors will have had a minimum of four years counselling experience, have experienced symptoms of compassion fatigue and have access to psychological therapy if required.

For the purpose of this research study I will be excluding counsellors who are; student counsellors, non practicing counsellors, counsellors who do not have access to psychological therapies, counsellors who do not belong to a professional governing body and counsellors who do not provide informed consent.

**What do participants have to do?**

If you agree to take part in the study, in the first instance, please complete and return the enclosed Consent Form and Questionnaire.

It is an ethical requirement of the University of Chester that participant's 'informed consent' has been obtained.

The Questionnaire will allow me, the researcher, to select counsellors from a range of backgrounds and environments. A summary of data from the completed

## APPENDIX 10. RESEARCH STUDY INFORMATION LEAFLET

questionnaire may be included in the final dissertation. All data collected at each stage will remain confidential.

Upon final selection I would like to invite participants to openly discuss their experience of compassion fatigue, which will take approximately 60 minutes to complete. I will contact participants to arrange a suitable date, time and venue for the discussion to take place.

The discussion will be in the form of a semi-structured interview, guided by open questions. These questions will be about participant's experience of compassion fatigue and counselling practice. With participant's signed consent this interview session will be audio tape recorded for transcription. An opportunity will be provided to debrief after the discussion. Participants will have access to the transcribed material and will be able to delete or amend any part of it.

Participants may withdraw from the research study at any time without explanation or fear of reprisal.

### **What are the potential risks involved?**

The potential risks are minimal and it is hoped that the discussion may be helpful in enabling participants to reflect upon their practice.

In the unlikely event further support is need, it is understood that participants will have access to their supervisor and/or personal counsellor.

### **Is the research approved?**

Yes, the project has been approved by the Department of Social and Communication Studies Ethics Committee and will be monitored by Supervisor Dr Rita Mintz. It will be conducted with full regard to the British Association for Counselling and Psychotherapy, (2002), Ethical Framework for Good Practice in Counselling and Psychotherapy.

### **Confidentiality**

Any information you provide will be treated in the strictest of confidence. All data collected at each stage will remain confidential. Only the Supervisor, the External Examiner and Researcher will have access to the audio tapes. None of your personal information will be disclosed. None of your identifying information (like your name and address, etc.) will appear on any of the record sheets: For the purpose of the study you will be identified by a code. You will NOT be identifiable in any part of the final thesis. A pseudonym will be used, for example, Participant A.

### **What are the benefits of this research?**

In carrying out the research, I hope to gain an understanding of how practicing counsellors experience compassion fatigue and raise awareness within the profession of compassion fatigue to enhance counsellors' well-being and therapeutic practice. I hope this will also make a valuable contribution to existing and future research.

## APPENDIX 10. RESEARCH STUDY INFORMATION LEAFLET

### **What will happen to the results of the study?**

The results of this study will be presented and made available in the form of a dissertation which will be kept at the University of Chester for reference and may be made available electronically. Without further consent the material may also be used in conference presentations or published research papers.

### **Data protection**

As a researcher undertaking the MA in counselling studies at the University of Chester, I have to follow strict laws regarding the Data Protection Act 1998. The information you provide will be treated with the strictest of confidence. All data will be securely stored and in line with University policy will be destroyed after a period of five years.

### **Do you have any other queries?**

If you feel you require any additional information or would like to query anything on this information sheet, I would be happy to discuss this in more detail. Please do not hesitate to contact me at [marilyn.lowther@btinternet.com](mailto:marilyn.lowther@btinternet.com)

**Thank you for reading this information sheet**

## APPENDIX 11. RESEARCH PRELIMINARY QUESTIONNAIRE

**UNIVERSITY OF CHESTER**  
**DEPARTMENT OF SOCIAL AND COMMUNICATION STUDIES**  
**Masters Degree in Counselling Studies**

**RESEARCH QUESTIONNAIRE**

**Research Study Title:**    **A Qualitative study of counsellors' experience of compassion fatigue**

Name: \_\_\_\_\_ M/F \_\_\_\_\_

Contact address: \_\_\_\_\_ Tel. No.: \_\_\_\_\_  
\_\_\_\_\_

1. How many years of counselling experience do you have? .....

*Charles Figley (1995, 2002) considers there is a cost to caring for those in emotional pain and suggests that we can be traumatized by helping suffering people in harm's way as well as being in harm's way ourselves. He identifies many symptoms of compassion fatigue such as: lowered concentration, powerlessness, irritable, lack of self satisfaction, withdrawal, somatic symptoms, low motivation.*

2. During your counselling career have you experienced compassion fatigue: *(Please tick)*

☐ To a limited degree      ☐ To a considerable degree      ☐ To a great degree      ☐ Not sure

3. Please describe the theoretical model with which you work

.....  
.....  
.....  
.....

### Details of counselling environment

4. Are you counselling in: (please tick which applies)

- ☐ Private practice
- ☐ Agency (please specify) .....
- ☐ Voluntary Agency (please specify) .....
- ☐ NHS
  - ☐ Primary care
  - ☐ Intermediate care
  - ☐ Secondary care
  - ☐ Specialised services
  - ☐ Other (please specify) .....

## APPENDIX 11. RESEARCH PRELIMINARY QUESTIONNAIRE

5. How many hours of face to face counselling do you provide per week? .....hours

6. Would you describe the type of therapy you provide as being:

☐ Brief (0-12 sessions)

☐ Longer Term (12+sessions)

☐ Long term (24+ sessions)

☐ Open ended

7. What range of client problems does the therapy you provide cover?

.....  
.....  
.....  
.....  
.....  
.....

8. What is the nature of any specialised service you provide (please give details e.g. eating disorder)

.....  
.....  
.....  
.....  
.....  
.....

**Thank you for completing this questionnaire**  
**Please return it with the signed consent form in the stamped addressed envelope provided**

### REFERENCES

Figley, C. (Ed.). (1995). *Compassion Fatigue*. Brunner/Mazel, New York.

Figley, C. (Ed.). (2002). *Treating Compassion Fatigue*. Brunner-Routledge, New York, East Sussex.

## APPENDIX 12. INFORMED CONSENT TO PARTICIPATE

### UNIVERSITY OF CHESTER

#### DEPARTMENT OF SOCIAL AND COMMUNICATION STUDIES

#### Masters Degree in Counselling Studies

### INFORMED CONSENT

**Research Study Title:** *A Qualitative Study of Counsellors' Experience of Compassion Fatigue*

(please tick)

- ☐ I have read and understand the information sheet about why the above named research is being done and what it will involve for me as a participant in the research, that my identity will remain anonymous and that all personal identifiable information will remain confidential and separate from the research data.
- ☐ I have access to supervision and personal therapy
- ☐ I am a member of a professional body
- ☐ I am willing to participate in the above named research project and understand that a summary of data from the completed questionnaire document may be included in the final dissertation. I understand that the questionnaire may be seen by Counselling Tutors and the External Examiner for the purpose of assessment and moderation. I also understand that these people are bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy. I further understand that a copy of the dissertation will be held in the University of Chester and may be made available electronically. Data from the questionnaire will be held for a period of five years and then destroyed. Without my further consent some of the data from the questionnaire may be used for publication and/or presentations at conferences and seminars with every effort being made to ensure anonymity.
- ☐ I am willing to participate in a one to one interview with the researcher to discuss my experience of compassion fatigue.

Name (please print) \_\_\_\_\_

Signed \_\_\_\_\_

Date: \_\_\_\_\_

**Thank you for completing this Informed Consent document.**

**Please return it to:**

**Marilyn Lowther**



## **APPENDIX 13. INFORMED CONSENT TO AUDIO RECORD RESEARCH INTERVIEW**



### **UNIVERSITY OF CHESTER DEPARTMENT OF SOCIAL AND COMMUNICATION STUDIES**

#### **CONSENT FORM ASSIGNMENTS INVOLVING AUDIO - or VIDEO – TAPE RECORDINGS**

I, ....., hereby give consent to be audiotape recorded and for the details of the session involving me and ....., to be submitted as part of an assignment for the Diploma in Counselling at University of Chester. I understand that, without my further consent, the transcript and recording of the session will only be used for the purpose of the professional development and training of the student counsellor.

This might include the playing of the tape to a counselling tutor, a supervisor, a small group of course participants led by a tutor, and possibly the External Examiner. I understand that all these people are bound by BACP Ethical Framework for Good Practice in Counselling and Psychotherapy, with regard to confidentiality.

I understand that the Department of Social and Communication Studies staff who are responsible for receipt, transmission and storage of assignments agree to respect my right to confidentiality in their handling and storage of this material, and that no further use will be made of this material without my further consent and that of the student counsellor.

Signed [Client].....Date.....

Signed (Student Counsellor).....Date.....

## APPENDIX 14. INTERVIEW GUIDE

University of Chester  
Masters Degree in Counselling Studies  
Research Study – Counsellors' Experience of Compassion Fatigue

### Interview Guide

Thank you for agreeing to participate in this research study entitled '*Counsellors' experience of compassion fatigue*,' and for providing consent for me to audio record this interview.

**I would like you to tell me about your experience of compassion fatigue**

**IMPACT**                      How did you become aware of the fatigue?

**CAUSE**                      I am interested to hear what you consider contributed to your experience of compassion fatigue

**AFFECT**                      I am interested to hear about any of the affects this experience may have had upon your work and personal life.

**SUPERVISION/SUPPORT**                      I am interested to hear about you supervision experience during this time.

**SELF CARE**                      Will you please tell me about what you found helpful and unhelpful at this time.

## APPENDIX 14. INTERVIEW GUIDE

University of Chester

Masters Degree in Counselling Studies

Research Study – Counsellors' Experience of Compassion Fatigue

**TRAINING/CPD** How would you describe the suitability and/or availability of training and continuing professional development for the type of counselling you provide.

**REFLECTION** Would you tell me what you have learned from your experience?

**FINAL COMMENTS** If there is anything you would like to add that is relevant to this research project please take this opportunity to do so.

*Thank you for this interview. I will send you a copy of the transcription of this interview which you are at liberty to modify in any way.*

*I will also remind you that you are at liberty to withdraw from this research project at any time?*

## APPENDIX 15. RESEARCH JOURNAL

|            |  |
|------------|--|
| 12/05/2009 | <p>Personal thoughts about fatigue: signs of fatigue: forgetfulness; double book appointments; disturbed sleep; easily upset; dizzy; headaches; tension; IBS; takes me longer to write counselling notes.</p> <p>What's been going on for me:</p> <ul style="list-style-type: none"> <li>• New role - grandmother</li> <li>• Husband semi retiring</li> <li>• Not attending health club for exercise</li> <li>• Changes in working organisation causing concern re future</li> <li>• Missing peers at college</li> </ul>   |
| 14/05/2009 | <p>Topics to consider for research:</p> <ul style="list-style-type: none"> <li>• What causes vicarious trauma – empathy or transfer of trauma on to therapist</li> <li>• How do therapists know if they are suffering from compassion fatigue/vicarious trauma/burnout and what do they do about it</li> <li>• How do supervisors know when supervisees are experiencing compassion fatigue or similar what do they do about it</li> <li>• My level of empathic responses and connection are usually deeper when related to the trauma or loss experienced by adult in their childhood.</li> <li>• Connected to the client at a deeper level.</li> <li>• Thinking about the impact of being empathically connected with client and containing emotion</li> <li>• Time restraints within the organisation</li> <li>• Environment not always compatible for the client's emotional expression – being aware of its limitations</li> <li>• The impact upon counsellors with the introduction of IAPT</li> </ul> |
| 20/09/2009 | <p>Decision to study therapists experience of compassion fatigue</p> <p>I wish to have a variety of participants and thinking of a spectrum of newly qualified counsellors to fully experienced counsellors, consider that a minimum of 4 years experience would be appropriate because of the likelihood of development their self awareness and provide rich information.</p> <p>Purposive sampling seems appropriate according to the literature and to ensure the participants have access to psychological therapy as a safeguarding against any possible distress as a result of discussing their experience. Debriefing will also be appropriate following each interview.</p>  |

## APPENDIX 15. RESEARCH JOURNAL

|            |  |
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|            | Thoughts and ideas about conducting a semi-structured interview and the possible prompts I may need in the form of an interview guide. I feel keen not to lead the participants and want to hear their interpretations of experiences.   |
| 21/09/2009 | Further reflected upon some more of the literature so far – The Resilient Clinician; The Body Remembers Casebook; Treating Compassion Fatigue; Help for the Helper.  |
| 17/03/2010 | <p><b>Criteria consideration</b></p> <p>Reflected upon the need to restrict experience of participants to 10 years maximum, originally considered because of the possibility of therapists becoming complacent. Following consultation with supervisor it was decided that there was no need to have a maximum limit.</p> <p>Considered possible tensions:</p> <ul style="list-style-type: none"> <li>• If I was trying to hide or ignore my tension/fatigue or likewise the participant</li> <li>• Could the participant be concerned I was checking up</li> <li>• If I sense a risk to the participant's practice – supervision issue</li> <li>• If I become fatigued by the participant's story</li> </ul>  |
| 18/03/2010 | <p>Conducted a pilot interview today which gave me the opportunity to experience the interview format and test my interviewing skills. I invited the participant to talk freely without using the draft interview guide. In fact all the topic areas on the draft interview guide were mentioned by the participant although not necessarily in the same order. Feedback was positive, particularly my use of summarising. I felt this provided clarity for me as researcher checking that I had understood what the participant had said and what was meant. It was welcoming to hear that the interview had provided an opportunity for the participant to express thoughts and feelings in a safe environment.</p> <p>Equipment worked well – unobtrusive but could be clearer for transcribing. I feel really pleased and excited about interviewing participants.</p> |
| 25/03/2010 | First interview – trepidation of finding the venue, meeting with the respondent and how this interview will be received. In reality the interview went very well with the respondent valuing the opportunity. Amazed at how generous this participant has been with the amount of experience shared.   |

## APPENDIX 15. RESEARCH JOURNAL

|            |   |
|------------|---|
| 27/03/2010 | <p>Query was raised by an interested respondent whether participants needed to be receiving personal therapy. I was able to clarify that this was a precautionary self care issue and that access to personal therapy was only necessary if needed.</p> <p><b>Response</b></p> <p>There was a greater response from advertising the research in Therapy Today than from using the mail-shot approach.</p> |
| 13/04/2010 | <p><b>REMEMBER</b> – Boundaries when interviewing participants. I am aware of being mindful in wanting to prevent a merging of boundaries particularly when holding any tensions within the interview. I trust that being aware that I could slip into counsellor role will prevent this from happening.</p>  |
| 15/04/2010 | <p>Contact with supervisor and discussion regarding pilot interview, use of interview guide and the preference for a shorter list of symptoms/impacts on the information sheet to future interested participants. I considered the possibility of a more elaborate list being interpreted as a method of diagnosis which is not my intention.</p>   |
| 22/04/2012 | <p>Reflection on completing first interview - feel pleased with the process, even finding the location! I experienced a warm welcome and the interview flowed well with plenty of dialogue. Participant appeared to enjoy the process and shared that it had been a valuing cathartic reflection.</p>   |
| 24/05/2010 | <p>I have now conducted my second interview and really have a sense that the research is underway. Again this interview went well with the participant having being open to share information and experience.</p>   |
| 04/06/2010 | <p>To immerse myself in the concept of fatigue I took time to reflect on my personal anxiety triggers and assessment of balance in lifestyle – what would happen if.....?</p>   |
| 10/06/2010 | <p>I have now completed third and fourth interviews both of which went well with participants being generous in sharing experiences. I have a strong sense of counsellors' dedication to their work.</p>  |
| 01/07/2010 | <p>Having now conducted five interviews I am aware of the similarities and the differences with regard to participants' experience and interpretation of the phenomenon. I am also aware of the different presentation styles.</p>  |
| 20/07/2010 | <p>Transcribing underway which is a long a laborious task. However it is giving me an opportunity to hear the participants tell their story again and for me to note significant issues, similarities and differences between each counsellors' experience. I am aware that I am beginning to analyse the data by noticing themes emerging. It will be interesting to see how</p>                         |

## APPENDIX 15. RESEARCH JOURNAL

|                          |   |
|--------------------------|---|
|                          | the more formal analysis progresses and if these themes remain.   |
| 13/11/2010               | Phone call from participant with additional information that occurred since time of interview.  |
| 26/11/2010               | Transcribing almost complete now – useful process to listen again to the information and hear the voices.   |
| 05/03/2011<br>06/03/2011 | Having completed all transcriptions I have begun to make notes of similarities and differences between participant's experience, work organisation issues and personal situations.  |
| 12/03/2011               | Having agreed to interview one more interested participant I feel completely nourished with information and honoured that so much experienced has been shared.  |
| 23/03/2011               | Final transcription complete – feel elated at completing another stage of the research.   |
| 25/03/2011               | Prepared transcriptions in terms of colour coding and line numbering ready for unitizing the data.  |
| 27/03/2011               | Continuing to read and re-read literature to keep myself focused on the subject.  |
| 28/03/2011               | Valuable time with supervisor to revisit a plan of action – once all transcripts have been approved by participants I can begin to code, colour and deconstruct the data.   |
| 21/04/2011               | <p>Transcripts approved and first stage of unitizing data for each transcript complete. I began by coding and marking each data set or transcript with pen. I then typed out a first draft list of units for each transcript.</p> <p>Although I first began by allowing the data to speak to me as it were, hoping that no bias would interfere with my conscious observation, I really do want to remain methodical in the process. Having lists with references seems really important right now.</p> |
| 07/05/2011               | <p>Noticing the impact of 'trauma material' not necessarily traumatising the therapist but effecting level of compassion and empathy for clients in relation to some participants and certain cohort of clients.</p> <p>Other issues – connection – training – supervision</p>  |
| 19/05/2011               | Attended lecture by Sue Wheeler which helped me consider in more detail the 'wounded healer' ethics of counselling, supervision interventions and the 'healing/stress matrix.   |
| 22/05/2011               | Completed second round of unitizing the data focusing upon impact.  |
| 23/05/2011               | Attended supervision. Supervision is such a valuable time that helps me keep focused and believe in myself. I can keep going with this study – one step at a time seems to be the best way to focus.  |
|                          |   |

## APPENDIX 15. RESEARCH JOURNAL

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| 01/06/2011 | Reflection on meeting with supervisor following unitizing the data which has identified themes – I need a general composite of each piece of data - thinking about epilogue – where will this have taken me. Decided impact is definitely more appropriate than symptoms or signals.   |
| 12/07/2011 | Focused upon supervision theme within data – breaking down what came up for each participant.  |
| 13/07/2011 | Re-read Maykut and Morehouse to refresh memory and understanding of methodology.   |
| 18/07/2011 | Third stage of unitizing the data complete – focus upon perceived causes.<br><br>Reflection on supervision session particularly with focus upon methodology chapter – feel grounded again. Good to have plan and targets for next stage.   |
| 24/07/2011 | Fourth stage of unitizing data for each transcript – listing aspects of supervision and support for counsellors with negative and positive aspects of this category.   |
| 25/07/2011 | I have been feeling quite focused and determined to maintain the momentum. Fifth, sixth and seventh stage of unitizing data for each transcript. <ul style="list-style-type: none"> <li>• focus upon training and CPD – again negative and positive aspects identified.</li> <li>• Self care which encompass many aspects</li> <li>• Reflection – breakdown of what participants identified or observed following the interview process.</li> </ul>  |
| 26/08/2011 | Produced units of meaning onto index cards which allowed another method of visualising the data. Some of the units fell into several categories, so I duplicated these units on index cards and put the cards into envelopes representing each of the categories.  |
| 29/08/2011 | Noticing the personal impact of this study, particularly reading so much about trauma and becoming immersed in the subject all whilst continuing to work in an organisation that is experiencing much change and instability. Colleagues feel insecure.<br><br>It's great that family are away and having fun whilst I get on with my analysis but it also feels rather isolating. I am aware of missing peers at college which was so supportive during module elements of MA. Lesson here about maintain a research support group of some description. |
| 01/09/2011 | Took time to consider the concept of organisations that are permeable and impermeable, particularly in relation to ethical standards, support and supervision.   |



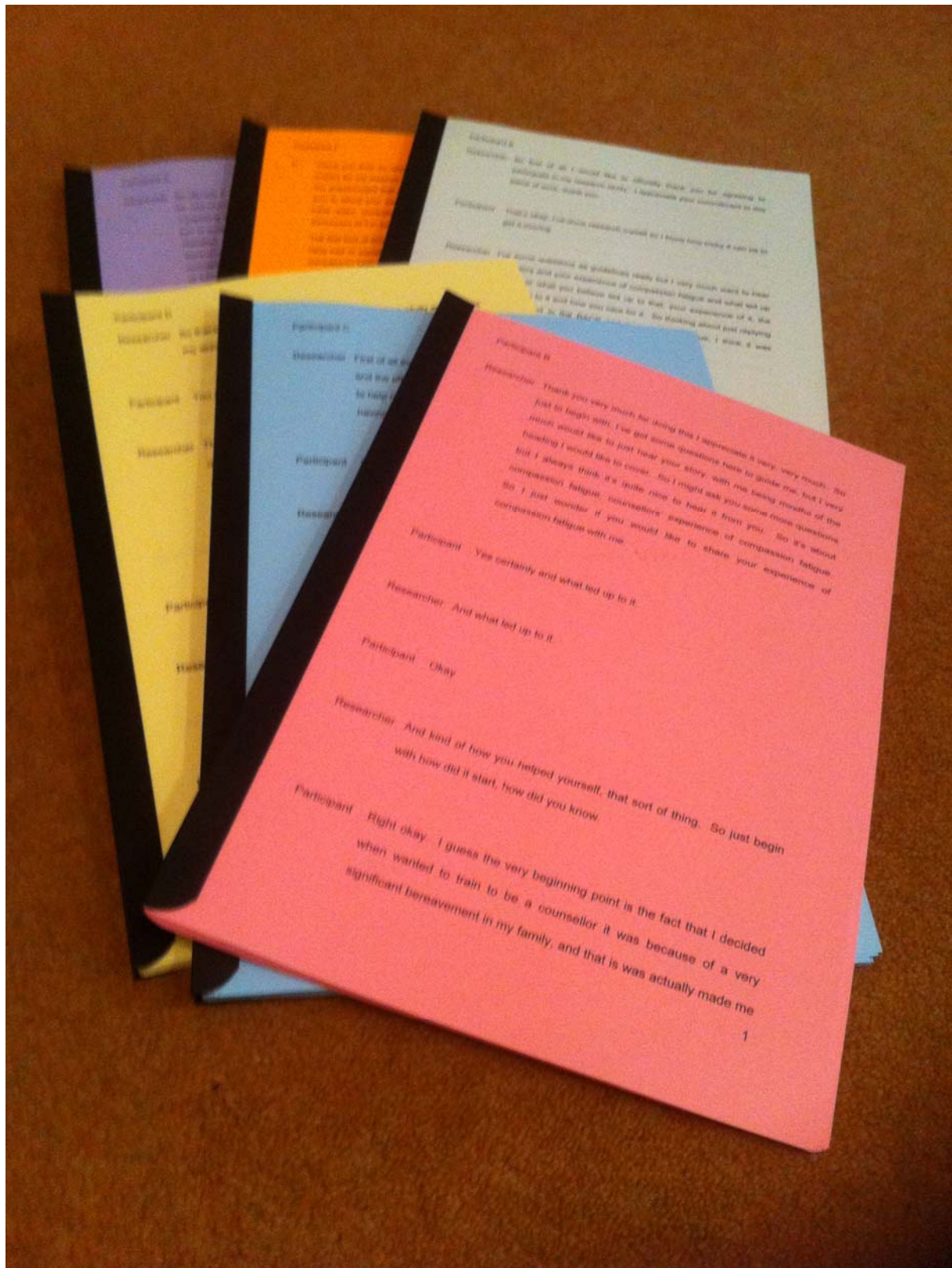
## APPENDIX 15. RESEARCH JOURNAL

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|--------------------|--|
| 05/09/2011         | First draft of outcomes complete for perusing and correlate with themes identified. Decided to re-read transcripts to observe any new themes that may have been missed.  |
| 12/09/2011         | Supervision – always grounds my thinking and helps me focus upon the study with a view to setting next tasks.  |
| 15/09/2011         | Ideas emerging for evidencing data analysis procedure/ audit trail – photos etc of the data cards and transcripts and discovery sheet.   |
| 20/10/2011         | Becoming aware of the concept of resilience within the client and counsellor – could this be a new piece of study?   |
| 24/11/2011         | Supervision – trying to meet a deadline and aware of time restraints, commitments and energy levels being depleted. Aware that I am pushing myself again and need to take a break.   |
| Further reflection | <p>Whilst engaged in this research process and being immersed in the subject I have also tried to maintain the demands, expectations, commitments (perceived and concrete) and desires of my professional and personal roles. As a result my health and well-being have been impaired from time to time and I have needed to redress the balance. This experience has made me consider the combination of causes relating to my fatigue rather than just the trauma related work I undertake.</p> <p>I feel the need to take a further break from the study, consider work case-load, prioritise professional and personal commitments and engage in some leisure and social activities.</p> |
| 09/01/2011         | Revisited research plan and plotted next stages.   |
| 18/01/2012         | Having had to take a break, complete other commitments and enjoy Christmas. Want to now re-connect with project and focus upon completion. Felt like going round the world before – late summer/autumn but now it feels like twins are on the way!   |
| 28/03/2012         | Supervision as enriching as ever. Now have achievable list of amendments and tasks to complete. Feel more in control now. Aware of what I have learned about the process of MA research and what different approaches I would take if I did a new piece of work. Reflected afterwards about the inspiration and sharing of new knowledge I provide to colleagues and peers.  |
| 14/04/2012         | <p>Printed off most major dissertation documents for perusal and amendments.</p> <p>I need to further consider introduction and conclusion.</p> <p>I need to write an epilogue and abstract.</p>   |

## APPENDIX 15. RESEARCH JOURNAL

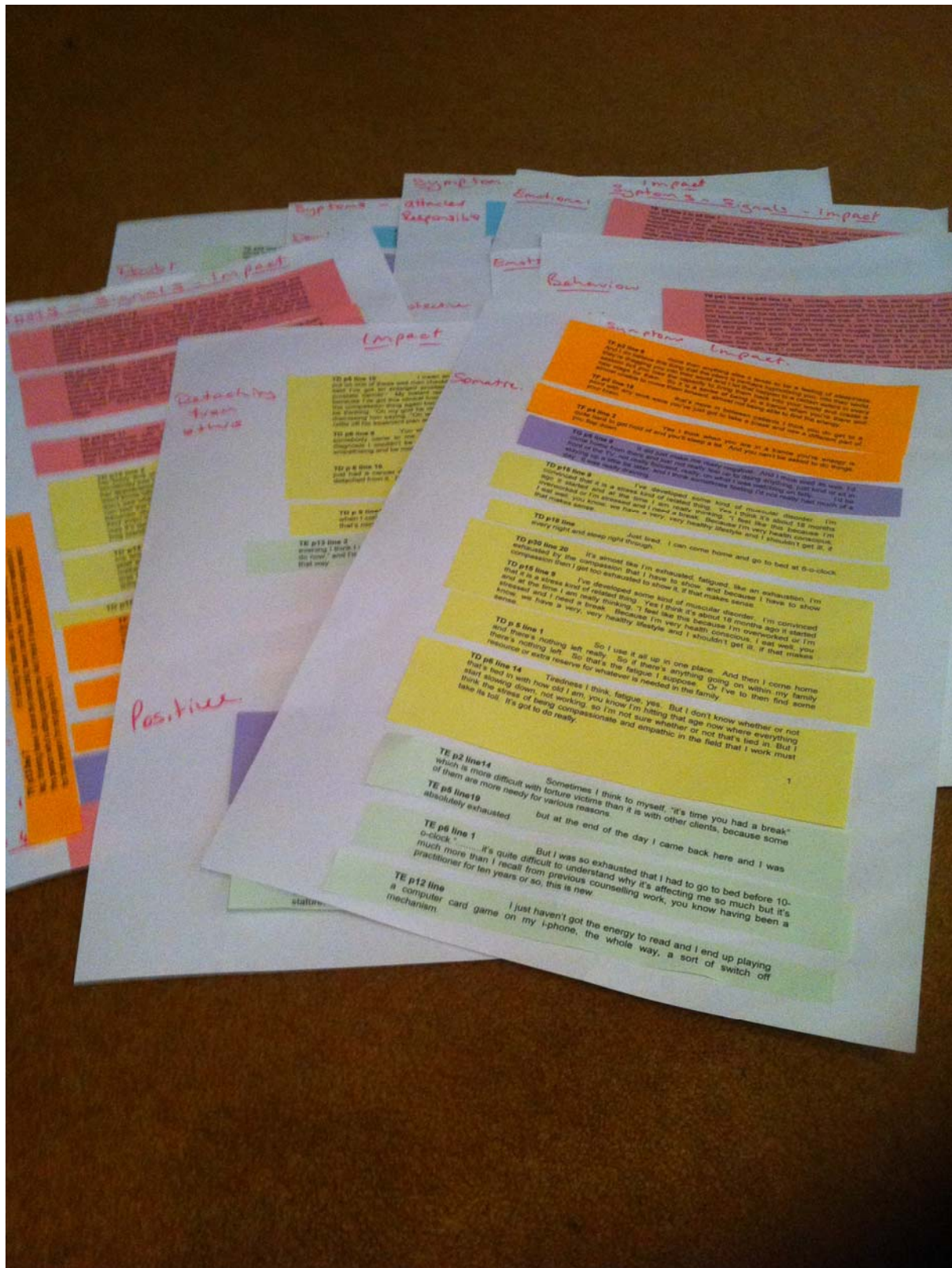
|            |  |
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|            | <p>There have been times when I have considered abandoning this study, it seems to have taken so long and recall several months ago not being sure I was able. I am so pleased I continued as it would have been a disrespect to the participants my tutor and my belief in self.</p> <p>I have been surrounded in books, journals and research articles which are neatly filed in my research box. What will it be like to complete this dissertation?</p>  |
| 24/04/2012 | <p>Reflected now how much I have learned from the process of doing this research and how differently I would approach a new piece of research. I really am aware of my increased knowledge in the subject and how I am able to draw upon my knowledge and share with peers and supervisees. It was my aim to promote self care as a result of conducting this research and I now feel able to do so with confidence.</p>   |
| 25/04/2012 | <p>Collating the appendix together now which is a great feeling.</p>   |
| 17/05/2012 | <p>Having written too much in my dissertation I have now reduced my word count which is sad in one way that all of my exploration and findings are not included. However I have developed a wealth of knowledge that influences my skills as a counsellor and helping me understand more theoretical process, particularly regarding trauma and the unconscious.</p> <p>Following today's departmental meeting in my place of employment it was welcoming to hear an organisational focus upon the welfare of therapists and the modelling of self care and mindfulness practice. I felt proud of sharing my study with a professional significant other who expressed an interest to read my dissertation and implement methods of aiding resilience!</p> |

## APPENDIX 16. COLOUR CODED TRANSCRIPTS – IMAGE 1.





## APPENDIX 17. UNITIZED DATA SETS – IMAGE 2a



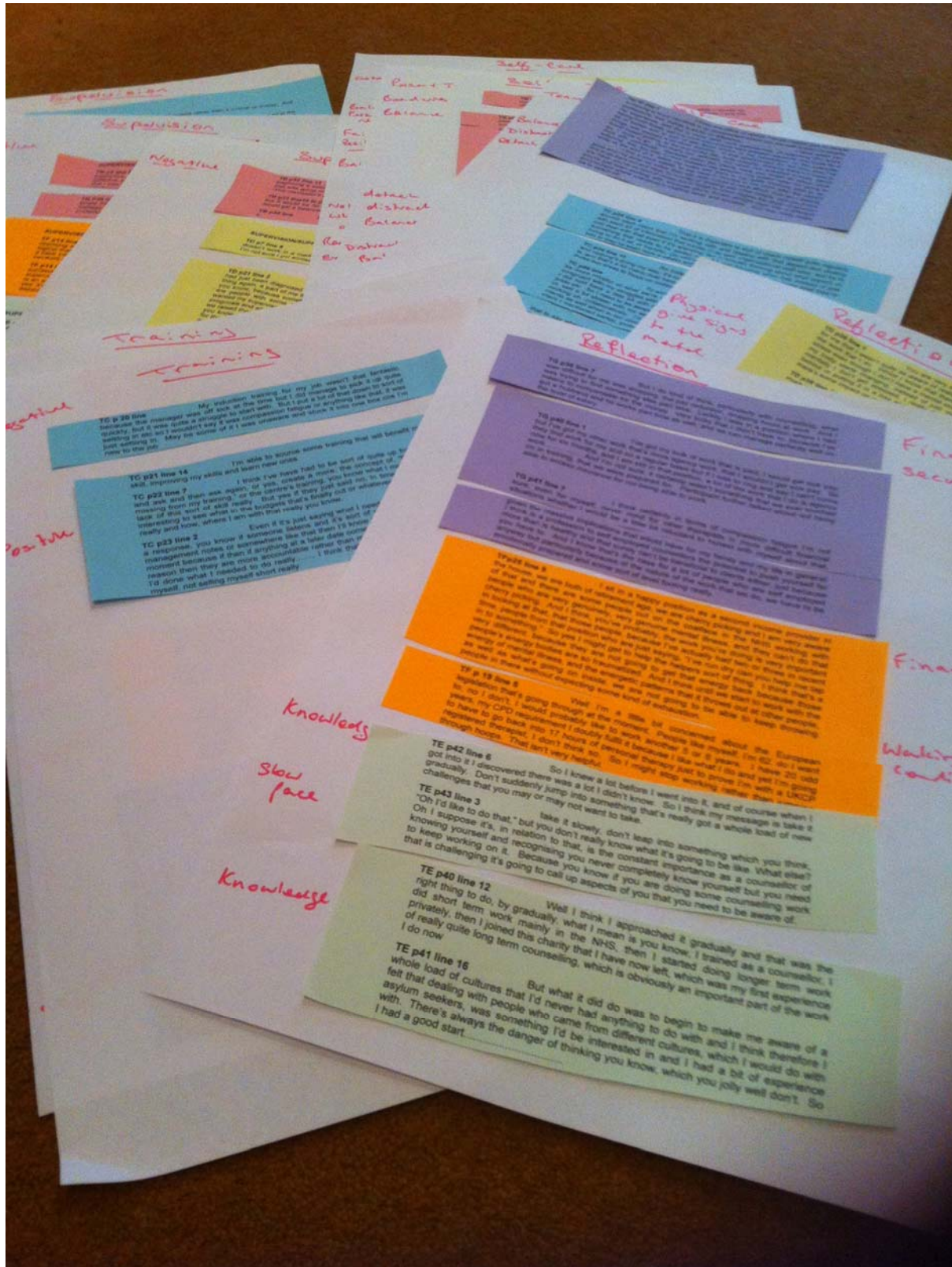


## APPENDIX 17. UNITIZED DATA SETS – IMAGE 2b



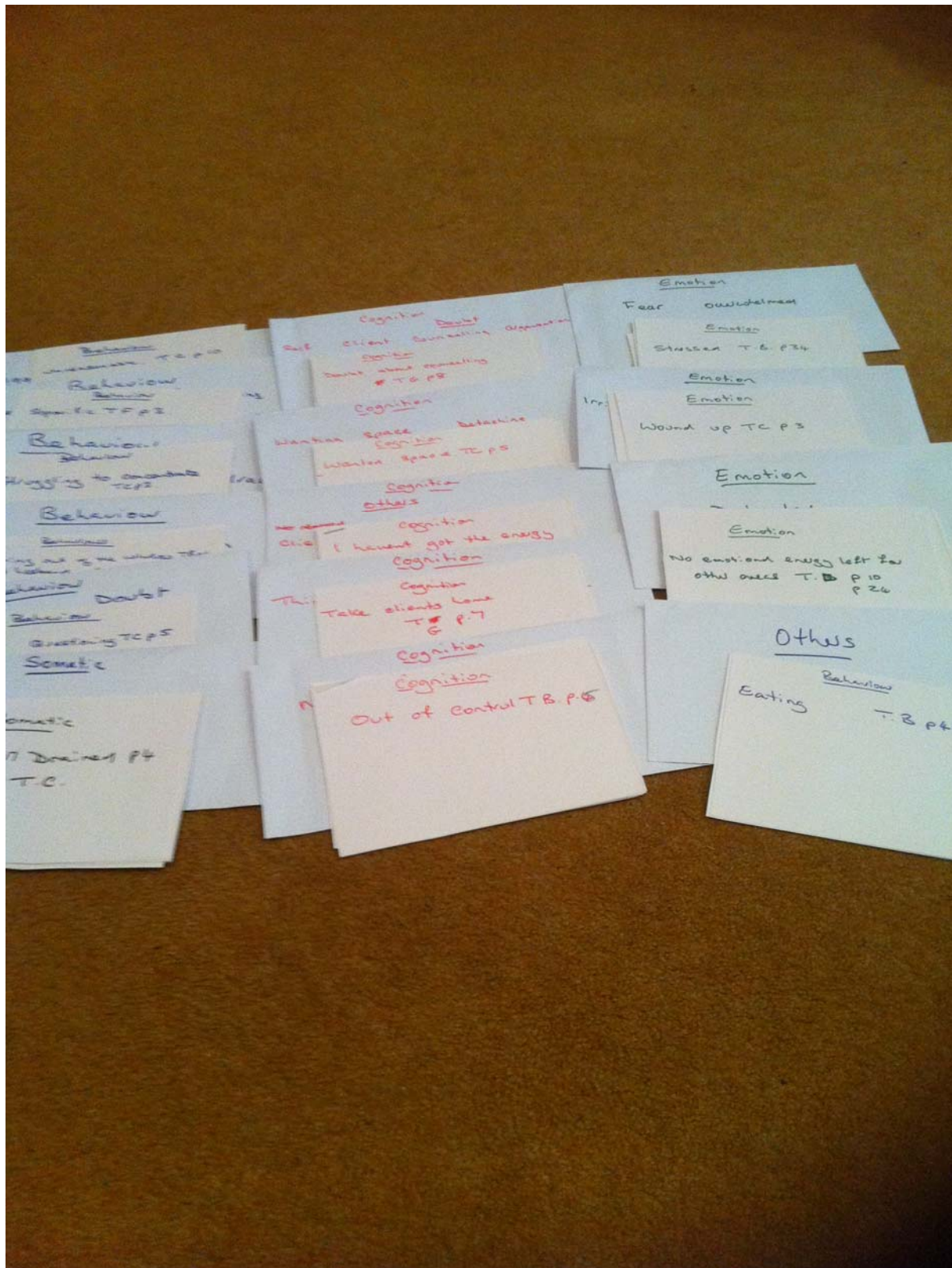


## APPENDIX 17. UNITIZED DATA SETS – IMAGE 2c





## APPENDIX 18. UNITIZED DATA INDEX CARDS – IMAGE 3



## APPENDIX 19. DISCOVERY SHEET – IMAGE 4





## **APPENDIX 20. INITIAL OUTCOME CATEGORIES AND PROPOSITION STATEMENTS**

- 1. How Counsellors experienced the impact of possible compassion fatigue**
- 2. What Counsellors considered may contribute to the cause of possible compassion fatigue**
- 3. How Counsellors perceived supervision and support during their experience of possible compassion fatigue**
- 4. How Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue**
- 5. How Counsellors perceived self-care in relation to their experience of possible compassion fatigue**
- 6. Issues arisen following Counsellors' reflection of their experience of possible compassion fatigue**

**1. How Counsellors' experienced the impact of possible compassion fatigue**

- How Counsellors experienced the behavioural impact of possible compassion fatigue
- How Counsellors experienced the cognitive impact of possible compassion fatigue
- How Counsellors experienced the emotional impact of possible compassion fatigue
- How Counsellors experienced the somatic impact of possible compassion fatigue
- Counsellors experienced the impact of having a sense of doubt
- Counsellors experienced the impact of detachment from clients, others, self

**2. What Counsellors consider may contribute to the cause of possible compassion fatigue**

- Counsellors considered that personal factors contributed to their experience of possible compassion fatigue
- Counsellors considered that issues in relation to the client contributed to their experience of possible compassion fatigue
- Counsellors considered that issues in relation to the organisation contributed to their experience of possible compassion fatigue

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**Additional propositions**

- Counsellors considered that working purely in a specialised services may contribute to their experience of possible compassion fatigue
- Counsellors are uncertain that hearing or observing traumatic material caused compassion fatigue
- Counsellors become irritated when clients do not engage which may cause fatigue
- Counsellors considered that being more attached to clients may contribute to their experience of possible compassion fatigue

- Counsellors considered they become more attached and responsible to clients when organisation/s appear to have insufficient ethical standards and practice
- Counsellors consider that when they have no power to change they become more fatigued by trying harder
- Counsellors consider they become more attached and responsible to clients when there is a risk for the client's safety outside of the organisation and therapeutic environment
- Counsellors consider that working in isolation may contribute to the cause of possible compassion fatigue
- Counsellors consider that being a parent, working with children may contribute to their experience of possible compassion fatigue
- Counsellors consider that they experience less compassionate understanding for Clients with lower level issues, than Clients with deeper level trauma related issues
- Counsellors do not become fatigued by the compassion they feel for Clients with trauma related issues
- Counsellors do not experience compassion fatigue when they observe a connection with the Client and even when progress is minute they have a sense of usefulness and personal growth
- Counsellors considered that having to write reports regarding their clients may contribute to their experience of possible compassion fatigue
- Counsellors considered that having to counsel through an interpreter may contribute to their experience of possible compassion fatigue
- Counsellors considered that having a dual role may contribute to their experienced of possible compassion fatigue
- Counsellors considered that having a dual role that conflicts counselling and with their therapeutic model may contribute to their experience of compassion fatigue

### **3. How Counsellors perceived supervision during their experience of possible compassion fatigue**

- Counsellors' positive perception of supervision during their experience of possible compassion fatigue

- Counsellors' negative perception of supervision during their experience of possible compassion fatigue
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**Additional propositions**

- Counsellors considered that they were supported by their supervisor
- Counsellors considered that they were able to be honest with their supervisor about whatever they were experiencing
- Counsellors considered that they were not able to be honest with their supervisor about whatever they were experiencing
- Counsellors considered that they were not challenged by their supervisor
- Counsellors considered that they were supportively challenged by their supervisor
- Counsellors considered gender of the supervisor was important
- Counsellors considered that they were not supported by management because their therapeutic work was not understood
- Counsellors considered that they were supported by management

**4. How Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue**

- Counsellors have positive and negative views regarding initial counsellor training
- Counsellors have positive and negative views regarding preparation for specific counselling work
- Counsellors have positive and negative views regarding continuing professional development

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**Additional propositions**

- Counsellors considered that personal development is an important part of initial counsellor training
- Counsellors considered there had been or is insufficient training in specific areas of counselling, for example working with children, loss and grief and induction to organisation
- Counsellors believed that continuing professional development opportunities was appropriate for their type of work
- Counsellors believed that continuing professional development opportunities was appropriate for their type of work and demanding due to the complexities
- Counsellors believed that choice of continuing professional development opportunities was available
- Counsellors believed that making and documenting requests from the organisation for continuing professional development is valuable
- Counsellors believed that knowledge about compassion fatigue is beneficial
- Counsellors believed that prior knowledge is useful for counselling, for example different cultures
- Counsellors considered that training could become too rigorous and risk loss of wisdom and experiential knowledge

**5. How Counsellors perceived self-care in relation to their experience of possible compassion fatigue**

- Counsellors use forms of distraction as a means of self care
- Counsellors create a sense of balance as a means of self care
- Counsellors believe self awareness is a means of self care

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**Additional propositions**

- Counsellors engage in reading as a means of distraction
- Counsellors engage in physical activities as a means of distraction and balance
- Counsellors engage in computer type games as a means of distraction and balance
- Counsellors engage in social activities as a means of distraction and balance
- Counsellors engage in taking holidays and regular breaks as a means of balance
- Counsellors engage in entertainment and laughter as a means of balance
- Counsellors attended to boundaries such as time management, not taking work home (detaching), reduce or mix case-load and separate roles as a means of balance
- Counsellors engaged in family activities as a means of balance
- Counsellors engaged in mindfulness and reflective practice as a means of balance
- Counsellors engaged in setting realistic targets as a means of balance
- Counsellors engage in personal therapy and talking and expressing emotions
- Counsellors considered that having a connection with clients and a positive outlook and belief is beneficial for self care

**6. Issues arisen following Counsellors' reflection of their experience of possible compassion fatigue**

- Needing to be supportively challenged in supervision
- New awareness of the physical impact of stress and needing to be more attuned to body
- Importance of gradual learning opportunities, appropriate training placements and supportive teams
- Importance of self awareness
- Importance of monitoring energetic patterns to prevent exhaustion
- Organisational responsibility for staff welfare, working conditions including employment and financial security

## **APPENDIX 21. FINAL OUTCOME CATEGORIES AND THEMES**

### **1. How Counsellors experienced the impact of possible compassion fatigue**

- Counsellors experienced behavioural, cognitive, emotional and somatic impacts of possible compassion fatigue
- Counsellors experienced having a sense of doubt about themselves as therapists, clients and the organisation
- Counsellors experienced impacts of attachment and detachment issues
- Counsellors experienced satisfaction and a sense of personal growth

### **2. What Counsellors considered may contribute to the cause of possible compassion fatigue**

- Counsellors considered that personal factors may have contributed to their experience of possible compassion fatigue
- Counsellors considered that factors in relation to the client contributed to their experience of possible compassion fatigue
- Counsellors considered that issues in relation to the organisation contributed to their experience of possible compassion fatigue

### **3. How Counsellors perceived supervision and support during their experience of possible compassion fatigue**

- Counsellors had positive perceptions of supervision and support during their experience of possible compassion fatigue



- Counsellors had negative perceptions of supervision and support during their experience of possible compassion fatigue

**4. How Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue**

- Counsellors had positive and negative views regarding initial counsellor training
- Counsellors' views varied regarding continuing professional development training

**5. How Counsellors perceived self care in relation to their experience of possible compassion fatigue**

- Counsellors used forms of distraction as a method of self care
- Counsellors created a sense balance as a method of self care
- Counsellors valued self awareness initiatives

**6. Issues which arose during Counsellors' reflection following the research interview regarding their experience of possible compassion fatigue**

- Needing to be supportively challenged in supervision
- New awareness of the physical impact of stress and needing to be more attuned to body
- Importance of gradual learning opportunities, appropriate training placements and supportive teams
- Importance of self awareness

- Importance of monitoring energetic patterns to prevent exhaustion
- Organisational responsibility for staff welfare, working conditions including employment and financial security

## **APPENDIX 22. PARTICIPANTS' COMMENTS IN RELATION TO CATEGORIES**

### **4.1 The impact Counsellors experienced from possible compassion fatigue**

#### **Counsellors experienced behavioural, cognitive, emotional and somatic impacts of possible compassion fatigue**

##### **Participant B**

I was seeing more and more people at my kind of age, women whose husbands had died and it started to affect me, I started to almost be my client. So I would think to myself, "if it's happened to them it could happen to me at any point, and it reached, it actually reached the point where I was coming home from say a evening meeting and I'd walk into the house and hearing my husband across the floor upstairs to come down to greet me, and I'd start crying with relief that I hadn't come home and found him collapsed on the floor, that kind of thing. And it was really, really difficult and M, my husband was, he was very supportive but he was getting very worried because I'd maybe stand at the window of the dining room and look down the garden when he was down there, almost like I was drinking him in because it might not be for much longer. And all these really quite black thoughts started to kind of come in.

Par-B:3:22 to 4:11

##### **Participant C**

Sort of, emotions were quite sort of stressed. I was feeling quite stressful, feeling quite angry and irritated as well because there wasn't that many staff to support me on this. I had feelings of sort of anger and pissed off with the client, thinking of the game that she was playing, do you know what I mean. I sort of, got sucked into it again and struggling to concentrate on where I what I was doing afterwards. I was viewing a house that Friday with my wife, so I was late for that etc you know. So I was pretty sort of wound up and trying to calm down and over the weekend I was sort of thinking that I hoped she gets sectioned and then I won't have to deal with it, you know what I mean.

Par-C:2:18 to 3:6

##### **Participant D**

I suppose I get emotionally drained and almost fed up with having to be compassion constantly, if that makes sense, because not only do I do formal contracted counselling work I also work on the wards and I support families. So quite a chunk of my work is actually being available and meeting people and introducing yourself to everybody that I come in contact with. So I am instantly in a compassionate mode, because people are coming towards us with people who are dying. More often than not in end of life we have to be compassionate, we all do. And sometimes I just get worn out by it.

Par-D:2:17 to 3:7

**Participant D**

And I think when I'm not in work, because, I mean, say an analogy of grieving (evening) perhaps I've got, I don't know, 20 lots of compassion in me in a day and then I use all of that up at work, so I come out of work, I have no compassion left. That's how it feels. So I use it all up in one place. And then I come home and there's nothing left really. So if there's anything going on within my family there's nothing left. So that's the fatigue I suppose. Or I've to then find some resource or extra reserve for whatever is needed in the family.

Par-D:4:15 to 5:5

**Participant D**

Tiredness I think, fatigue, yes. But I don't know whether or not that's tied in with how old I am, you know I'm hitting that age now where everything start slowing down, not working, so I'm not sure whether or not that's tied in. But I think the stress of being compassionate and empathic in the field that I work must take its toll. It's got to do really.

Par-D:6:14 to 7:3

**Participant D**

Researcher Do you notice any parts of your body that is affected by it?

Participant Well it's interesting that you should say that because I've developed some kind of muscular disorder. I'm convinced that it is a stress kind of related thing. Yes I think it's about 18 months ago it started and at the time I am really thinking, "I feel like this because I'm overworked or I'm stressed and I need a break. Because I'm very health conscious, I eat well, you know, we have a very, very healthy lifestyle and I shouldn't get ill, if that makes sense.

Researcher You look after yourself?

Participant Yes, and my body, my muscles are giving me a lot of problems so I think that's a manifestation of stress really.

Par-D15:9 to 16:5

**Participant E**

I'll come back to another example of, but at the end of the day I came back here and I was absolutely exhausted. I'd only seen two clients and nothing had gone wrong, you know, that was, every day I go X, it was a completely different, experience from every other day. But I was so exhausted that I had to go to bed before 10-o'clock. I'm fine this morning, you know, I have got that characteristic I recover, as long as I sleep or have some sort of respite. And it's quite difficult to understand why it's affecting me so much but it's much more than I recall from previous counselling work, you know having been a practitioner for ten years or so, this is new.

Par-E:5:18 to 6:6

But actually I haven't been so irritable in the last few months, and it's interesting that I wrote that, I must have been experiencing it then, but I haven't, or have I, yeh I was

irritable, when was it, it was one night this week, it was something to do with work I think. I think it may have been Tuesday night, after I'd had seen these two difficult clients and I was a bit snappy at home in the evening, I mean not, not major, but I was snappy. So I was still irritable, yes.

Par-E:38:6

### **Participant F**

But if there's just a general sense that I'm running dry I think it's perhaps compassion fatigue. I just think if one more person tells me they're having an awful time at the moment I shall clock them one. It that kind of, it's a very human reaction.

Par-F:1:19

But I think more than anything else it tends to be a feeling of sleepiness. And I do believe this thing that the client is perhaps hypnotising you, into their world, they're dragging you into their world and I let that happen to a certain extent in every session but you lose the capacity to bring them back into your world and create a new stage for them. So it is a sense of being in a trance when you're there and almost unable to move them forward, almost not being able to find the energy.

Par-F:2:6

### **Participant G**

I think it's the only time in my work when I've found myself at times coming away from a particular session, having 50 minutes with a child and having to think right I need to go and have a cool off period. I couldn't just sit and do my notes straight away and a couple of occasions where I'd been quite upset, particularly where there'd been situations where there's a limit, and quite alone in it really, on what can be done with the situation.

Par-G:2:8 to 3:1

### **Participant G**

I think one of the side effects it definitely did have was making me a bit more kind of protective really with my own son. Certain things I'd be more aware of, so kind of little behaviours that are probably quite average for a lot of children but when you see it displayed in a child that's got a lot of difficulties, emotional difficulties and its really highlighted I'd pick up on a lot with my son at home, it was probably quite relevant to him but would then kind of worry me. And I think it did just really get me down in the end.

Par-G:5:1

### **Participant G**

And I think tired as well, it was the couple of days a week that I've had where, you know, I can see clients now, I can see 6, 7 clients in a day and I'm fine you know, I can do a dance class at the end of the day, go and meet friends. And I'd come home from there and just not really feel up to doing anything, just kind of sit in front of the TV, not really focused, really, on what I was watching on telly. And I found myself sitting there again towards the end of that, I'd be staying up a little bit later, and I think sometimes feeling I'd not really had much of a day. It was really draining.

Par-G:6:10

## **Counsellors experienced the impact of doubt about themselves as therapists, clients and the organisation**

### **Participants' experience of having doubt about themselves as therapists and the organisation**

#### **Participant C**

Yes I did feel quite alone. And sort of stranded with the ultimate irrational fear that was going on, Oh xxxx say something does happen, are my notes up to date, you know what I mean, etc. Am I on top of it, of my paperwork, whether I. I questioned a bit of my practice I suppose as well really.

Par-C:5:4

#### **Participant E**

And one man there suddenly said, "So what are you working on with this client." And I thought, "xxxx," what am I working on?" Which is exactly what you've just talked about. "What am I working on?" And it really worried me and this was right at the end, we ran out of time, and I set off to the train and it was going round and round in my head, asking myself, "Am I doing what I should do, am I being a proper counsellor for this client." I got on the train and I thought, "What the hell are you talking about, you are a person centred counsellor, you're working with his sense of self and you're trying to help him to become, you know, the person that he can grow to be, you know, that's what you're working on, why the hell did you worry about it."

Par-E:36:18

#### **Participant G**

And just that sort of feeling of helplessness, I think really, with it. And I think it got to a point towards the end of the 2 years that I worked in that environment where I would just not want to go in the morning, so I'd be kind of getting in the car and sometimes thinking I've the frame of mind that I didn't even know whether I was helpful being there because of how I felt about it.

Par-G:4:5

#### **Participant G**

I ended up having quite a negative view of particular social services because my experience of it in that environment was pretty shocking and I think that had a knock-on impact in the other work that I do where I have communications with the social services, which kind of wasn't helpful to me anyway really, across the board.

Par-G:5:18

## **Participants' experience of having doubt about client's ability to progress**

### **Participant C**

Researcher Did you know it was compassion fatigue and if so how?

Participant I think, I've done a little bit of reading up on it some time ago, about 18 months, and I think it was, I noticed it because I was making a lot of judgments and opinions of clients, what I was thinking of the client, how I was thinking with them and how they were progressing, if I was thinking quite negatively, they ain't got a chance in hell of getting sober because of this and that. So less hope I think is one of the aspects and my view of the client and their progress of what they've done so far.

Par-C:8:6

## **Counsellors experienced the impact of attachment and detachment**

### **Participants' experience of being or wanting to be detached socially**

#### **Participant C**

I was quite irritable at home I think, quite snappy and not quite so, I wanted a quiet space and not to be asked questions.

Par-C:5:10

### **Participants' experience of being detached from clients**

#### **Participant B**

And then I found myself sitting with clients and not, to be perfectly honest with you I was finding it difficult to engage, particularly with assessments, because at assessment you're hearing much the same, over and over. And I could feel myself physically kind of tightening up and thinking, "I can't listen to this, I just can't listen." And it was really, really difficult.

Par-B:4:11

#### **Participant F**

Researcher So you are describing a sort of more robotic state, mechanical, robotic.

Participant Yes, or I'm sitting there saying 'well how do you feel about that,' without actually engaging. I become non-engaged and that is not okay because it is through my engagement and through my energy that we bring in the patient's energy. Yes, saying those words, that's what it is.

Par-F:13:6

### **Participant's experience of being detached with clients who appear to have lower level issues**

#### **Participant G**

Participant Yes, well I think for some people, what I do find sometimes is that clients take on that other perspective, you know it's an alternative perspective that's being offered, to actually take a step back from their own situation and evaluate, okay how bad is this compared to, how that would feel and I think that can be really helpful when, there are certain types of clients, and I'm not sure what sort of personality it would maybe come under, if any, you know I'm not in the business of

categorising really, but there is definitely a certain type of client who doesn't take that too well, that they almost seem to want to have drama, they want something going on, they are quite reluctant to look at it from any positive perspective, or see the light at the end of the tunnel really. And I find that quite difficult, in terms of the fact that they referred themselves to counselling because they want to progress and get something out of it and then there is almost a refusal to move on from what they feel.

*Researcher* So no matter how much compassion or empathy you share with that sort of client there's a block, they don't want to move.

*Participant* Yes, and I think if you get

*Researcher* What's that like for you?

*Participant* A certain point into that, quite frustrating. And I think once I recognise the sense of frustration I find it really difficult to be quite as involved, I do purposely, then again I don't think purposely is the word, but I definitely know I'm doing it, and I withdraw emotionally to a large degree, the compassion and the empathy that I felt for the other person isn't really there to a large degree.

Par-G:19: to 20:6

## **Participants' experience of being detached emotionally from family and friends**

### **Participant D**

A flatness really, a dead liner. And I suppose don't get moved by like I used to do. Emotionally moved, or tearful. I mean an example was the other week my husband had put on one of these well men checks and he'd come back and he'd said, "The doctor said I've got an enlarged prostate, and that could indicate, an early indicator of prostate cancer." My instant reaction was, "Well you're only 50," you know and because I've got this clinical knowledge I know that that's not a big deal. But this is the compassion thing again because if I didn't work in the industry that I work did I'd be thinking, "Oh my god he might have cancer." Whereas my husband I'm sort of dismissing him saying, "Oh well you know, you haven't and if you have," and I can rattle off his treatment plan and the fact that he would be cured.

*Researcher* So for your family you will focus upon the facts rather than the emotional element.

*Participant* Yes that's good, yes, I do yes.

*Researcher* And what about your own emotions connected to your husband, it sounds as though you focus upon facts.

*Participant* Well then I have, I suppose to find this reserve that clicks me back into, "You wouldn't talk to somebody at work like this would you." (laughter). If somebody came to me for counselling because he'd just had a cancer diagnosis I wouldn't be so clinical and so and so empirical and detached from it. I'd be empathising and be more compassionate.

Par-D:5:7 to 6:12



It does in some respects because people know I'm a counsellor so they tend to sort of think that you ought to listen to their problems and I really don't, I am really, really not interested at all. And last year a friend of ours was diagnosed with breast cancer and her husband had said to my husband, "Do you think that A would talk to, you with." And he said, "Probably not really, because you are friends." But a big part of me thinks, I thought, "I really don't want to go here, I'm not interested, I know you're my friend but right now you've got lots of support around you and I'm not getting involved." And I think they were quite hurt by it really, the fact that I didn't come forward and be helpful and caring and compassionate. I just completely distanced myself from it, to the point of not really asking how she was doing.

Par-D:8:2

### **Counsellors experienced satisfaction and a sense of personal growth**

#### **Participant G**

Yes, there's something quite genuine, that I couldn't if I wanted to just say I'm going to switch off now and I've had enough. So there is some sort of gain for me there, some sense of feeling useful, I think. And when I feel that with clients I am always okay. Even if I've had a full day, I might have seen 5 or 6 people in a day and particularly one of the agencies that I work with where it can be really heavy going in the day, and there's always some sense of, even if I've got things to contemplate and my own emotions to kind of process when I come away, there's almost as though I get some sense of personal growth from that. It reinforces that actually, it's been worthwhile going there today and you know I might be tired, feeling a little bit drained sometimes but that's okay.

Par-G23:4

#### **Participant G**

Yes, I think just a sense that you, then again I'm never quite sure what the process is specifically, it's different with each person. I think it's about the relationship and the way we relate to one another, and a lot of the time it can be sort of body language, or those subtle things, that there is a definite connection, there's something going on there for the other person and that I feel as well, I sense that it's worthwhile. And I think as long as I feel that I don't think I could feel fatigued by the level of compassion or empathy.

Par-G:22:15

#### **Participant E**

so the clients we see have very often lost very much of their sense of self, their self respect, all those things that we try to encourage as counsellors so that's one of the main tasks which, you know, I've noticed it happening, you know we are not talking about torture, we are talking about lots of other things and the client grows as a result. And obviously I'm talking about psychological growth that, it's very interesting that one client whom I'd seen for about six months, when I started seeing him, he was a small man anyway, but he appeared very small, he's not old, he's in his early thirties, his trousers were torn, dirty jacket on, you know he really looked destitute, I mean he was close to it anyway, but I mean he really looked it, and after six months, well actually a bit less than that, he grew over six months and I started thinking, he was different, there's something different about him. And my supervisor knows him as well, and we started talking about it, and she said, "I know what it is, he's

bigger.” Which is exactly right, he’s bigger, I mean he’s not bigger in stature, but he’s bigger as a person, yes, he holds himself differently, I think he might be slightly rounder in the face, you know he’s not so gaunt. But it certainly had a big affect upon him.

Par-E:33:18

## 4.2 What counsellors consider contributes to the cause of possible compassion fatigue

### Counsellors considered that personal factors may have contributed to their experience of possible compassion fatigue

#### Participant B – a personal performance anxiety meeting demands of organisation and leading to a merging of boundaries

I felt a great deal of pressure to perform and to be seen to be this amazing person and so the first two or three years I really went for it and the job became full time within six months, so. But what was happening of course was that I was, the Trustees and the management needed to see figures, they always need to see the figures, so okay we've got this new counsellor, how many people is she actually counselling, how many assessments is she achieving a week and all about how we're going to build the services so that it becomes a gold standard service for the area.

Par-B:3:7

#### Participant B

*I was bringing work home.* So that if I'd done an assessment and I needed to refer them to a member of the team and I knew they worked during the day, I'd only get them in the evening, I would be bringing the paperwork home, ringing them in the evening, I was bringing clients into my home who were grieving. I had their paperwork here, I had lists of things to do here and it was too full on. So we worked on my boundaries and how, what I should be doing in fact is, when I leave work I lock everything away in a filing cabinet, I lock the office, I walk away and then I have my life at home, just completely separate. So we worked really hard on those boundaries where *I'd gone by, really merging my work and my home life to a very unhealthy state.* So we worked on the boundaries stuff and I was able to do that quite well actually and it felt a relief, because *somebody had given me permission to not be a workaholic if you like, and be constantly trying to prove myself.* But of course all the time you've got the Board of Trustees and the Management looking at your figures and seeing if you are worth the money and all this in their world. So there was still that, and so I was still a bit anxious about my performance if you like.

Par-B:6:21

#### Participant D – having personal trauma issues

Not at work, no I think the last 2 years I've been affected by circumstances in the family. Had that not happened I think life would have been a lot different, you know, there's been, work for me, I mean is a big chunk of my life but equally home is a bigger chunk and things at home have been very traumatic. Not so much now, because we are 2 years on, it feels like things have settled to a normal pace, but we are only just reaching that now in 2 years and I think the compassion fatigue has been exacerbated by what's being going on at home really and having to keep separating things and changing my focus, switching off from this and switching on to that. So I think without that I don't think I'd be feeling like I have been feeling.

Par-D:37:10

**Participant G – personal demands and working in a specific area**

I think I've had certainly various points in my work really where I've experienced compassion fatigue to a lesser or larger degree and sometimes that's a kind of one off and you know doesn't occur again even with the same client. But I think there are two particular occasions, one when I had a lot going on at home and I actually cut down the amount of clients I saw in a week and I've maintained that as well, a lower level. And then particularly, I worked a couple of years back with children, for two years and I think that was my biggest experience really of compassion fatigue.

Par-G:1:12

**Participant G**

I think weighing up the balance really between having them have somebody there to offload to and talk in their own time and what their expectations might be to confide in an adult, was their expectations sometimes that something would be done or something would change and of course having to then put across to them that's not what this time was about, that we were spending together, was just incredibly difficult emotionally. I don't think it helped that, at the time, I've got a son myself who was a similar age group to the children I was working with, primary school age group, and I'm not sure whether that maybe kind of compounded the impact really for me.

Par-G:4:10

**Participant C – similar cohort of clients**

In a way because a lot of the client issues are quite similar to previous client we've had and can be quite the same, sometimes it's like working at Tesco's you know what I mean, same story difference faces. And that sort of by checking myself, how much I believe it, and if I believe it quite a lot, then I know I need to sort of take a bit more care of myself, of course they are different stories but they are all unique in their own right really you know. And that's not too helpful to try, again judge them and make opinions of people.

Par-C:13:12

**Participant D – becoming unconsciously familiar with working environment and constantly conveying compassion, but also expecting herself to give more compassion**

I thought the terminology compassion fatigue was very much around me at the time. I work in a hospice so I work with families and patients who are coming to the end of life really. But I also work with people affected by cancer. And cancer is a massive spectrum from an almost insignificant tiny little grain sized lump to something that can be huge that takes over your whole body. And I think because I deal with it day in and day out, for me it's normal. You know, death, dying, bad news, chemotherapy, to me it's just normal, standard routine and I think occasionally I need to stop and remember that actually this is a one off lifetime experience for some people and it's terribly traumatic. But because it's part of my normal work I don't see it as anything separate and I am consciously aware that I am not, I could slip into not being as compassionate as I should be because it's not special, it's not different to me.

Par-D:1:14

**Participant D**

I do formal contracted counselling work I also work on the wards and I support families. So quite a chunk of my work is actually being available and meeting people and introducing yourself to everybody that I come in contact with. So I am instantly in a compassionate mode, because people are coming towards us with people who are dying. More often than not in end of life we have to be compassionate, we all do. And sometimes I just get worn out by it.

Researcher So what you said is that because it's routine, you have to sometimes remind yourself to be more compassionate.

Participant Yes.

Researcher Because it's routine, the environment in which you are working is routine to you but it's not routine to the individual client or family member?

Participant Yes.

Researcher But then you are saying actually sometimes you feel that you are being over compassionate, almost that you are having to be compassionate all the time. So is that something about your level of awareness of, the level of compassion that you are providing? You know when you were saying, "I have to remind myself to give more."

Participant Yes and I guess for me the times when it's brought me up sharp at work has been when I've heard comments from relatives that are nursing staff. And one that stood out in my mind was this woman said to me, "*I know it's your everyday work but I am only going to be with my mum, my mum's dying, she will only die the once, whereas you are dealing with family after family after family.*" And it made me realise that yes everyone who comes in our doors is experiencing this for the first time. And it just made me more attuned I suppose to perhaps what they needed from us.

Researcher Right. And then you're asking yourself to be more compassionate?

Participant Yes.

Par-D:3:1 to 4:13

**Participant D**

And I suppose that's where the compassion fatigue is, I suppose it's obvious there's more of a compassion fatigue because to me it's routine and it shouldn't be routine really. You know the fact that people coming in to us and, I mean for example at the moment we've got a young woman who is 32 and I've been working with her for over a year and she's got this horrendous tumour that's breaking out of her body and she's got like this rugby ball on her chest and on her back and for somebody just coming in to meet this young woman, you'd probably be horrified, by her appearance as well actually because she's so disfigured now. Whereas to me, I don't know whether it's compassion fatigue or not, I just accept her how she is and I don't see what the disease has done to her as much, but she's living with it and she can feel the changes every day. So with her I have to make more of an effort now because

she has become the norm for me where she's absolutely not the norm. And even within the work that we do she's very rare in the type of cancer and the way it's developed. So it's almost like the extremes of cancer, sometimes there a bit bog standard and they shouldn't be.

Par-D:12:14 to 13:14

**Participant E – having a reaction to hearing experience of trauma and it not having a long-term affect or causing compassion fatigue**

Yes, it's very strange because it's got this combination which worried me when I first started hearing it, of being horrifying and you know sticking in your head, is horrible, and horrible because of its affects on your client but also fascinating. And I got worried when I first noticed that, when I was hearing it I'd only had about five or six clients when I heard them describe what happened to them, and I thought there was something strange about me, so I talked to my supervisor about it, and she said, "No it's quite normal we all have that." So that was a bit of a relief really, but it is weird, it's weird. I'm just trying to remember whether, you know, in the small hours, if it's one of those nights when I wake up and can't go back to sleep for an hour or two, whether. It runs round in my head, it runs round in my head if, I think, if there is something about my job as a counsellor which I'm uncertain about or dissatisfied about, or worried about it doesn't run round in my head because it's torture. You know, what I worry about as a counsellor is, "Oh should I do this, should I do that, should I have been picking something up, or earlier, what do I do about that client, you know do I refer to somebody else, did I handle that meeting well." Those are the sort of things that go round in my head in the small hours and not how horrible the torture is.

Par-E:35:1

**Participant C - having some difficulty with responsibility for therapeutic and intervention balance and the possible adverse consequences for the client**

I suppose it's about being mindful if I believe I'm working harder than the client, then I need to sort of be congruent with them with that really and give them some ownership back, that it's their lives and their recovery etc and it's up to them to grab hold of that really rather than for me to be carrying on telling them or chasing them up for this or that it's sort of – they are adults, which is important thing to remember really that they are adults and they are here to engage with the service and there's limitations as well you know. You can only do what we can do for them, if they don't get it, you know what I mean, it's not my responsibility.

Researcher It's not your responsibility, so there's something about the client having responsibility for the input.

Participant Yes, yes.

Researcher So there could be a tendency, is that what you are saying, that when the client isn't working, if you like, you do more?

Participant Yes, yes, that's right. To motivate them or get them to shift or whatever.

Researcher And you find that hard work?

Participant That can be quite frustrating because it's there you know it's like sort of a missed opportunity with, because anything is possible in a way, if they don't get what they need to get out of it and then leave and start abusing and drinking then death is an option, you know or you know a lifetime of misery you know.

Researcher So are you describing then a situation where you are working with a client and the client isn't working and you are doing more work than is required of you and then you get frustrated that this client hasn't achieved anything?

Participant Yes.

Researcher So something about you accepting that not everything can be done?

Participant Yes, the limitations I suppose in a way.

Researcher I see. Being mindful of the limitations?

Participant Yes. And I have worked the other way when other clients have completed and come up to the unit and said thanked, thanked staff, or whoever's working with myself even personally, "thanks for pushing me and giving me that nudge," you know because they were doing okay but, you know what I mean, they were resting up a little bit and because we were aware of it I was able to give them that little bit more of a push and more work to do, so they were able to gain the benefit of it as well really. Because there, I suppose that's where I'm at, the struggle is getting the balance when, how long to rest up and to get grounded and then when to come in and when to speed things up you really.

Par-C:27:1 to 29:13

### **Participant E**

It's the magnitude of what happens if you don't do these things. Sorry you were talking about boundaries, which I agree with, but I'm trying to put another element in which is the magnitude of this person's situation and how dangerous it is and how much they need support, whether I can, I suppose, I can deliver it or not.

Researcher He's built up a trusting relationship with you.

Participant Yes, am I going to fulfil that? Can I do what's necessary?

Researcher So I'm sensing an element of pressure there on you in terms of responsibility.

Participant Yes that's right. Yes it's funny that you've just mentioned that. I've not quite looked at it in that way but yes it is in a way a greater responsibility. In a way I wouldn't like to say I'm more responsible for those people than I am with other clients is that, if we fail one of these clients we believe that they could easily be killed within a period of time. So the stakes are so high, that's the problem.

Par-E:11:1

**Participant E**

Yes that's right he was withdrawn, so it's very difficult to know with that particular client, do I leave the silence, for how long, do I make an assumption about what he wants to talk about because of what we'd talked about before, what is the most appropriate thing. This is a situation shared by many counsellors there, it's quite a big organisation. But, you know because so many of the clients are withdrawn for many months or years.

Researcher So asking yourself all those questions, you are kind of doing the work by yourself?

Participant In a way, I'm working harder than I would do with the clients actually that make it clear what he or she wants.

Par-E:14:3

**Participant E also encountering difficulties with lack of emotional connection with the client**

for three months we've been trying to find a Lawyer to represent this individual because he needs really quite specialist legal advice in order to make a fresh claim for asylum here. And we found one, well my boss in X, found one. And we said it's good news for him because he's really frightened that he'll be sent back to where he came from and fears that he will be arrested, tortured and probably killed, you know, that's his fear. So to find the lawyer was a good thing. Well yes, it is a good thing. He said I'm relieved but there was no emotional signals of that at all, which is not uncommon with torture victims, especially in their early years of treatment and hopefully recovery because they're completely withdrawn emotionally. So it's that sort of thing that well I wouldn't say it doesn't upset me but it's so counter to the way I'm thinking, as a person centred counsellor I'm thinking this is good news, good news to find a lawyer, what a relief.

Par-E:4:7

**Participant D – having no positive outcome**

I just think it's the nature of the work really. I think if you spoke to any of our nursing team they would probably all tell what I'm telling you. I just think it's how it is when you are working with this kind of people that we are working with. There's no good end result apart from somebody having a peaceful death where they die, with peace of mind and a contentment and pain free. We are not going to change anybody's, because I always think of counselling as being a dynamic really that takes you from where you are to where you want to be. And at end of life, where they want to be is often just pain free.

Par-D:11:8

**Counsellors considered that issues in relation to the organisation contributed to their experience of possible compassion fatigue****Participant C – lack of organisation policies and procedures established**



Yes, that's a clinical example. I another example was sort of organisationally, sort of policies and procedures at times. That sort of infringed upon my practice in a way.

Researcher Policies and procedures?

Participant Yes around, around mainly an away day around the development plan. And we all sort of found, the staff of the unit all sort of done what they needed to do and were waiting for the new organisation to shift the ass really and sort out what they need to do. But it didn't exactly sort of happen really, so that caused me quite a bit of stress as well really. And sort of affected my client work as well really because it was quite sort of suggested that everything was going to be a lot easier when this happens and that happens and then it keeps getting postponed and postponed.

Par-C:6:1

### **Participant C – working in a residential setting**

Yes, quite intense, five days a week you know. So I work where they live in a sense so we get to see more of the behaviours and interactions with other residents as well.

Researcher So although you are not having therapy, you are not in therapy with a person all day you are observing some of the behaviours, you're absorbing?

Participant Yes, and likewise they are observing us as well, so we are on show as well in a way, so the boundaries are quite important there really, not giving too much away, personal dialogue, being aware of whose around, in what room, if you are in a room just chilling out etc. And being, they start a conversation with each other when you're in a room or whatever, it's just to do what you need to do and know when to come in and say something or not really, you know.

Par-C:44:3

### **Participant E – difficulties with having a dual role – advice and persuasion for example**

So my, one of my jobs, if that's the way to look at it, in a counselling session was to try to get him to accept that the lawyer that we found for him he could stick with and in fact I think it worked, he was part way there and various things I said to him helped and I had a final thing to say which was connected with political beliefs that I reckoned would really do the trick which it did. So it was good, but it's not counselling. So I think that's maybe one major point in all this, I have to do things that aren't counselling. So there is a sort of inner conflict going on, you know I know it's in the interest of the client and it's got to be done, we've been with him for six months and I know he trusts me, we've got a good relationship, you know, so I, you know, I know I can do it, but it's not the way I'm used to doing counselling. But that keeps happening all the time.

Well I was actually trying to persuade him, not to just reassurance. I was saying, you know you've got to stick with this man, he's good, we've use him frequently, he really knows his stuff, I am sorry he was rude to you and we really apologise for that and we talked to him about it.

Researcher So coming out of counselling mode? That inner conflict.

Participant Yes, that therefore means that not only is there an inner conflict which I think is one of the thing that contributes to the tiredness and the stress of it, but also there's the difficulty switching. I've always found it really difficult to switch between what I feel is me as a counsellor, a person centred counsellor, with all the characteristics that I've come to use as a person centred counsellor, to switch from that to somebody who would say, what you've just told me makes me concerned about your safety because you talked about taking your own life and we need to do something about that, and to start thinking clearly about that. In a way it was different from being a person centred counsellor. That shift is always difficult for me and I've spent a lot of time with supervisors trying to make it easier, an practice does make it easier. But I should always find it tricky and with the torture victims I'm having to do that all the time in different circumstances.. So I think that's one of the reasons why I find it so.... more demanding

Par-E:7:16 to 9:9

### **Participant E – dual role - working with an interpreter and different cultures**

And the interpreter, afterwards, the male interpreter, when we had the debriefing, said, "in our culture you can't ask people to do that, you know because he is going to be disrespectful to somebody at some point, either to me or to the woman." So he didn't say you can't do it but people won't make that decision, they just won't do it. So there's those cultural things that come up you know where you think, I wish I'd known that because it would have made a lot of difference. So of course the whole thing is fascinating, this is one of the reasons why I do it but it is a strain.

Par-E:31:14

### **Participant E**

One of the debriefing functions is if the interpreter has been traumatized by what he or she has to interpret, there is a chance to go through that with the counsellor, so in a way we become a counsellor for the interpreter.

Par-E:32:12

### **Participant E – dual role - having to produce reports**

Contact was made by Participant E, following interview to advise that he does have to produced reports.

One of the main things the Foundation does is to provide very stringent reports done by doctors and lawyers on torture of that person, which can also include the counsellor's report, and that is then used as part of the application to the UK Border Agency for leave to stay, so it has to be very very well done. And so we have had training on that too. I don't really do it myself but I did know about it because clients are going through it, and that's traumatic because they have to not only say what happened to them in great detail, but they are examined physically and the doctor tries to find physical evidence of torture, which is the most effective way. So I'm just giving you a few examples of why the work demands so much more time and brain power because there are all these other elements to it.

Par-E:27:14

### **Participant G**

And I think the other really difficult element of that work was having to compile any sort of report and trying to work with children on a basis to give them a good

understanding, make them remember as you go through each session, of what they say, you know, isn't always confidential, caused a lot of conflict for me and my way of working. Because ordinarily unless there's a suicide risk for example it is completely confidential for all my adult clients, and that I found very difficult. I'm not sure counselling and therapy from that perspective is always that suitable, if the trust in the relationship seems kind of false. And again I think that was another element that really made me question why I was there, you know whether I should carry on or not.

Par-G:7:10

**Participant E – having moral conflict with organisation and responsibility to the client creating difficulty with attachment issues**

I thought it is a good opportunity to get away from this place. And in fact talking about stresses, that in itself became stressful because I'd had a number of long term clients there and it was a very difficult decision to decide how to say goodbye to them, if I was saying goodbye to them. I left plenty of time, there was about 2 months, so being able to say goodbye wasn't a rapid thing. If I say goodbye to them how will it go and how difficult and also with some of them, will they be able to cope on their own or do I need to find another counsellor for them. So that was a stressful period in itself. I suppose if you look back over the last, well certainly in the last year, but particularly the last couple of months it's been quite heavy.

Researcher So leaving an organisation where saying goodbye, level of responsibility, is the client ready to say goodbye, so more responsibility on your shoulders?

Participant That's right, yes. The place wasn't run very well, not run very well and erm there were a number of things there that I felt were not ethically correct over a long period. I mean not major but they were just, they were symptoms, to use your word seems appropriate, of an organisation where the management of that charity was not doing its job as well as I think it should do. So it had been going on for a long time, I'd say for 18 months I thought I don't know if I want to stay here.

Researcher So how, did you find that impinged on your work?

Participant What it did was to, for around, I'd say 18 months, certainly a year ago I said to myself "I'm not going to take any new clients here, I know I am going to leave at some point. One or two of those clients were asylum seekers as well. It was a voluntary organisation, they had people referred to them who were asylum seekers and so I was working with phone interpreters with those asylum seekers and my supervision for that was in the place I worked in M because that work is very close to the work I did with torture victims using interpreters, working with people from another cultures and languages and trauma people who are threatened to be returned to their country. So that was another stress. I was the only counsellor doing that work and I tried to get somebody else assigned to it from about 18 months because I knew that something would happen where we would suddenly need two of us, and the organisation hadn't done anything about it, which didn't surprise me, but that was the case, so when I left those people probably aren't going to get a counsellor.

Researcher And you were working in isolation.

Participant Working in isolation but also it's that responsibility thing again. I felt responsible, I knew that was the right thing for me to leave but it meant leaving a gap which I tried to fill and didn't succeed. Yes so when I started listing things there was a hell of a lot of stuff in the last two or three months that was quite clearly a stressful.

Par-E:18:7 to 20:15

**Participant G**

I'm not sure that, there were only a couple of children I worked with where I would kind of take that home, which is very unusual for me, with any client. Where there've been concerns that I've passed on to other professionals whose role it was to do something with and kind of continuously getting the feed-back that, "Oh you already know and we're working on it," basically, and knowing that I wasn't at power to change that, still sending particular home to pretty horrible environments sometimes, while they collected enough evidence to actually remove them from the family home

Par-G:7:2

**Participant G**

There's something overly caring, over responsible. And I think some of that was born of kind of knowing that there weren't other people, quite often, other adults who were taking that personal responsibility for any given child that I was working with. And feeling somebody should.

Par-G:10:3

**Participant G**

If I'd a child referred to me, there were problems at home, social services just got involved, you know, they might want to talk about what's going on for them and so had to follow that through and so that would be at times, 12 months of knowing and actually reporting back before what they're experiencing before anything is actually done. You know the fact there has to be a certain number of times documented by a number of professionals and, very, very difficult I think to switch off from that at the end of the day, when you are wondering has the some other person done what they needed to do, have they got this message or this e-mail or. And certainly with social services, not even always being told what happened as a result of the information that you've given them, other than we are working on it, we've acknowledged it.

Researcher You are being kept in the dark a bit?

Participant Yes. And then you could come in and have a session booked with somebody and they'd say, "Oh they left on Friday." They had gone to another school or whatever, gone to another family.

Researcher So a really close attachment and a sense of not knowing as well.

Participant Yes and the same for the child really that there was no way of preparing them for, okay in a couple of weeks time this might be a possibility. And I don't feel we were ever really prepared for that which was very, very difficult, especially on the occasions when I had had information through, you know, conversations with other professionals that, it was a likely outcome that they were

going to be removed from the family home. But they didn't ever tell the children until it happened, which I just find pretty shocking, quite honestly, and very, very difficult to cope with.

Researcher Sounds like you are really hot on ethical and moral obligations, generally, as a person.

Participant Yes I just sort of feel misleading people to any degree isn't fair but when you are being asked to do that on a professional basis because you've got information that they don't want you to share with children, or that you're working on the basis that we're going to meet again next week and the week after and then suddenly that doesn't happen. There some sense of wondering whether that made it worse for them.

Par-G:12:5 to 14:3

### **4.3 How Counsellors perceived supervision during their experience of possible compassion fatigue**

#### **Counsellors have positive perception of supervision during their experience of possible compassion fatigue**

##### **Participant C**

I generally get it fed back to me from my supervisor, telling me that I've got quite a rigid approach and a lot of my colleagues challenge me on it and I'm able to pick it up fairly quickly. I think I sort of intermittently dip in and out of it, sort of mildly compassion fatigue, although my process, "Ok now what's sort of going on and able to check in with myself really and think what I've just said or really place interactions I've had with colleagues or clients.

Par-C:10:11

##### **Participant D**

Our supervision sessions are quite structured, we are a bit CBT, really actually the way we approach it. We will start off with how I am personally, how I am, how things are at home, how I am physically, anything going on for me that's significant, before we move on to my caseload. Because in the last 2 years, 2 years ago my sister had a massive stroke that's left her in a nursing home and her youngest daughter came to live with us and that whole thing was a major trauma in the family. You know and so much changed, she was only 11 at the time. I mean, all our kids have left home, you know, so there was a huge thing so my supervisor was very supportive then and quite, you know, conscious of my workload, my home-load. Everything was like load, load, load. So she's very good like that. She questions my caseload weight and in supervision I take a full list of everybody that I see and we talk about people that I want to talk about. And at random she will pick up other people out really, so she gets a sense of what I'm not telling her or what I'm not bringing her. I feel very well supported there.

Par-D:18:11

#### **Having additional support from colleagues who are not counsellors**

##### **Participant C**

De-brief with colleagues really around, like you do in groups or workshops or one to one, because it's a residential, everyone else sees where the clients are at as well. So you get another perspective in a way, which is quite useful in a way, because sometimes it might be just my perspective like that that's seeing it, someone else might be saying, "Well actually I have seen her doing this, this and this.

Par-C:18:3

##### **Participant D**

But at work I've got a clinical director, who is a doctor, my line manager is our clinical services manager, and I can go and talk to them at any time about, if I've had a really bad session, well I've had an emotionally draining session I've got somebody I can go to and sit with and let it go, if I need to.

Par-D:19:11

**Participant G**

Yes my supervisor does always, pick up on, she's very aware of the difference in me with the sort of clients that I'm working with and the issues that I'm working with. She always kind of comments on how strong I am really, and my ability to work with, particularly when we look at things like sexual abuse which is what I work with quite a lot. I almost thrive by that working environment, that sense of being there for somebody, and again there seems to be some sense of purpose that she picks up on, more enthusiastic, even if there's been times where I've been a bit stuck or I've got things that I need to really think about how best to work round, to work with this. And quite involved. And then she does pick up quite often, and she will say, "Well okay what clients have you had at such and such a job." And then, quite obvious to her from the outsider's perspective, even in the way that I've put across, and she has to actually ask me, "Okay what about this other group of people?" And I'll say, "This was just," and she will always highlight if I've used the word just, that's normally a starting point for our discussions around that kind of thing. I don't think. She's certainly always quite positive about it overall and gives me that kind of reminder of, "Okay what's your reason for going in that room, being there with that person? And encourages me I think to purposely connect and be empathic with those people because that's what can help them to get something out of the sessions.

Researcher So you have the same supervisor for all of your work?

Participant Yes, an integrative supervisor and she, I do work with person centred and CBT primarily along with systemic work, transactional analysis, other bits that I've put in over time. Whereas she, I think the person centred side of things for her is different and she has qualified in a whole host of other therapies. And she brings a lot of new perspective really. And seems to rationalise much more, and I think this is where I've got this sense of rationalising, splitting the two types of work with clients, is from my work with her primarily.

Par-G:24:1

**Participant D – Positive and negative values of external supervision**

External's fine really because she's not accountable to the organisation, she's accountable to me I suppose in a way that she provides good supervision, and she's a very experienced supervisor. The down side I suppose is that I work in an environment that she doesn't know, so I am almost educating her at some times. But she comes up to the mark very quickly.

Par-D:20:10

## **Counsellors have negative perception of supervision and support during their experience of possible compassion fatigue**

### **Experience of able to be selective in what is discussed in supervision without being challenged by the supervisor**

#### **Participant B**

Now my supervisor at the time was fantastic, she was really supportive, but I felt ashamed of how I was feeling. So I actually, I was a bit selective about what I took to supervision. So I would go in and talk about clients that I was particularly enjoying working with, because there were some. But I didn't really address the thing about the assessments feeling overwhelming, because I was doing, I don't know, six a week, assessments, plus having a client list of about eight. I mean these were all people who were grieving and in despair. So I felt a bit ashamed at the time, so didn't. I was quite selective, thinking, "I can work this out myself, I'll be fine."

Par-B:5:6

So with my supervisor I was able to go in with, as I said at the beginning a selective list of topics so that I could very successfully hide the trauma that was going on within me because I felt that she would report me to the BACP. "This counsellor's got compassion fatigue, she can't work in bereavement any more."

Go in all bright and breezy and I'd say, "Right I've got two clients I want to share with you and then could I show you what I've written of my sessions for my accreditation." And I'd draw into all of that, be very up-beat, very jolly and.

Researcher Did she ever challenge that?

Participant No, no that's how she was.

Researcher Did you ever wonder why?

Participant No because there would be times when I would, there were times I would go in and I wasn't as jolly, but it would be for something that I felt okay to talk about. So when M had his hip resurfaced, we were moving into this house, he was having his hip resurfaced, I had to go away for a week's conference, the London one, it was all happening at once. I was really stressed out all this stuff going on. So I would take stress things that it felt wasn't my fault.

Par-B:32:13 to 34:2

#### **Participant D**

One draw-back, the last time I saw her she told me she had just been diagnosed with bowel cancer and I suppose this is this compassion thing again, a part of me thought, "Oh," I didn't want her looking for me for support, you know, because sometimes you look around and everywhere around you there are people with some form of illness who wants support and I didn't feel that I wanted my supervisor to then start asking me things about cancer and diagnosis and prognosis and all the rest of it really.

Plus the other side of that was, and we raised that at supervision, was that I'm bringing people who've got bowel cancer, you know, I'm talking about somebody, I'm giving her a précis of what's happened for the client and



after the track from diagnosis to where we're at, is a very fast track and I said, "I'm very conscious that I'm going to be talking about people with bowel cancer who aren't going to get better."

But then part of me thinks you know, as a member of the human race, I should be caring about everybody anyway, you know, and not just thinking, "That's your job in my life," because it's not as cut and dried as that is it really, it's a bit more furry round the edges..... I suppose this is where this compassion thing comes in, part of me thinks, "She's paid to be my supervisor," you know, she's paid, and I know it's a two way relationship, like it would be in counselling, but the onus is on her to support me and not me to support her really.

Par-D:21:2 to 22:12

#### **4.4 How Counsellors perceived training and continuing professional development in relation to their experience of possible compassion fatigue**

##### **Counsellors have positive and negative views regarding initial counsellor training**

###### **Participant B**

There was a huge amount of personal development.....And we had personal development groups .....they really felt they got to know me, as a person and that I was very transparent. But that was actually hugely beneficial to my development as a counsellor. And I was prepared to do that. But maybe, thinking about it, talking to you now, there was an element of actually these people were in a way a nurturing parent that I hadn't had and I was able to say things to them and not get criticised for it. It was okay. So in lots of ways they had a massively positive impact on me starting this journey. And also reinforcing my decision to train to be a counsellor,

Par-B:37:9

##### **Counsellors' views varied regarding continuing professional development**

###### **Participant B**

Actually the CPD that I'm choosing to do now is nothing to do with dying. I've done so much death and dying CPD I now choose to do other..... In 'Therapy Today' a day of personal development, creative therapy and coaching

Par-B:39:8

## 4.5 How Counsellors perceived self-care in relation to their experience of possible compassion fatigue

### Counsellors use forms of distraction as a method of self care

#### Participant C

I play golf, sort of intermittently in the winter but quite a bit in the summer, like once maybe a fortnight, once a week. I go out and walk the dog in the morning and the evening. I'm not doing much study at the moment so that's quite helpful. I spend quite a bit of time playing computer games, a bit of brain recovery time.

Par-C:12:4

#### Participant C

I try and let it go as well really and train my mind around that, **just not thinking about work**, just chilling out and not getting caught up and getting resentful about the policies and procedures and all that stuff and just accepting it a bit more really and dealing with it when it comes up rather than trying to control and regulate things you know what I mean. Wait to see what happens first, just quite a lot of energy is wasted in "What if I do this, this and this." And then I'll go and ring work up and that person is on holiday and so it's about just staying in the here and now.

Par-C:12:13

#### Participant E

Oh I do what I've done for quite a few years which is physical exercise..... And so there is that and there's gardening, there's DIY, all of which I and then there's the bit that I find difficult to admit to but I think it's relevant is I've got one particular computer card game that I'm obsessed with and the reason I'm obsessed with it because I'm always trying to win it better. But it switches me off, it is a distraction and I find that very useful. So often when I get back home, you know, after a day I think what shall I do and I inevitably do an hour of that before I do cooking or watch television or whatever..... I think it has a sort of psychological numbing, I don't think it's numbing, it sort of, yes it's a concentration, a complete concentration on something totally trivial and different, not involving people and it sort of, it washes away some of the concerns of the day.

Par-E:44:6

### Counsellors create a sense of balance as a method of self care

#### Participant B

So we worked on my boundaries and how, what I should be doing in fact is, when I leave work I lock everything away in a filing cabinet, I lock the office, I walk away and then I have my life at home, just completely separate.

Par-B:7:3

#### Participant B

And there was an article in Therapy Today at one point about bereavement work and it did suggest that you can't just do bereavement work for long. And I thought yes this person's right and this is what I'm doing. And that was the point that I decided that I needed to do other work as well which is when I set up private practice from home, seeing people, only people who have got other issues, apart from the death of a loved person.

Par-B:8:11

**Participant B**

And just the work/life balance .....I think it's really important now..... I'm trying to find a line dancing class..... quite often just take ourselves out.... walk down the canal and out into the countryside ..... actually be much kinder to myself and let things go..... I can prioritise now, which I didn't used to do. So things get left and I'm okay with that and I never used to be.

Par-B:43:6

**Participant C**

I will see you at 12 o'clock rather than 3 o'clock on Friday. And so I prepared myself a bit more really.

Par-C:3:12

**Participant D**

I think I'm going to need an operation on it, and I thought if I get a week off work now in June and then I can choose to have the summer, I can choose when I can have this operation, I'm spacing my time off work. So that's an element of self care really in that I'm trying to pace things to my advantage.

Par-D:26:12

**Participant D**

we are up in the hills in the country, we've got half an acre of land, we've got an old coach house and it's very pretty and very picturesque and it's just a delight being at home..... we've got a very good family and every month or so the whole clan come to us for a meal or a 'do' and that's, it's work, it's labour, but it's enjoyable and I really like that. I like having all the family round, because there's babies in the family now, we have grandchildren, you know that's part of.

Par-D:28:7

**Participant E**

When I worked in x I actually took a week off every six weeks, roughly speaking, and I can't remember how I was able to do that because the holiday allocation was, there was something about the hours, and I don't do that as regularly now. That's partly because I'm only working three days a week, but I think I ought to do it more regularly. I keep on telling myself.

Par-E:43:15

**Participant F**

I find two things, one is to take a break if I can. Every two to three years we take a one month to five week sabbatical, and we travel, that helps enormously, or physical activity.

Par-F:2:2

## **Counsellors value self awareness initiatives**

### **Participant F**

I have turned to a female counsellor for myself for that because I was aware that I was almost running the problems people were bringing to me, against my own problems and thinking “what have they got to complain about,” which is the wrong position to be in. But then there were sessions when I was thinking, well actually what have I got to complain about, so it has a dual effect. But I resorted, used a female psychodynamic counsellor to help me. I needed pushing to face what was going on in my life, so I think perhaps I bracketed that.

Par-F:14:9